

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07599

Reg. Dist. No. 302

1. PLACE OF DEATH:
Washington
 County.....
 City or town..... **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... **Lifetime**
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution?..... **3 Days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... **Maryland** County..... **Washington**
 City or town..... **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **128 N. Locust Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME

Robert Blair Adams

3.(b) Social Security Number

NONE

4. Sex..... **Male**
 5. Color or race..... **White**
 6.(a) Single, married, widowed, or divorced..... **Single**
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) **Nov. 21, 1947**
 8. AGE: Years..... Months..... Days.....
0 8 1..... hrs. min.

9. Birthplace..... **Hagerstown, Washington, Maryland**
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name..... **Richard Scott Adams**
 13. Birthplace..... **Hagerstown, Md.**
 14. Maiden name..... **Natalie Stockslager**
 15. Birthplace..... **Sharpsburg, Md.**

16. Informant..... **Richard S. Adams**
 Address..... **128 N. Locust St. Hagerstown, Md.**

17. **Burial** Date thereof..... **July 25, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... **Mt. View Cemetery**
 Location..... **Sharpsburg, Md.**

18. Funeral director..... **Edith V. Lear**
 Address..... **Williamsport, Md.**

19. **July 24, 1948** Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **7.22.48**..... 19..... at..... M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7.21.48..... 19..... to **7.22.48**..... 19.....
 and that I last saw him alive on **7.22.48**..... 19.....
 Immediate cause of death..... **Acidosis.**

Other conditions..... **Pertussis.**
 (Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results..... **No pathology found.**
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE..... **St. H. Powers**
 Address..... **Hagerstown, Md.**
 Date signed..... **7.24.48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

1638

07600

302

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Days
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown St.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1021 Corbett St
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS BERTHA MAY ANDREWS

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William
 6. (c) If alive, give age 70 years
 7. Birth date of deceased (mo., day, yr.) July 13 1884
 8. AGE: Years 63 Months 11 Days 24 If less than one day
 hrs. min.

9. Birthplace Hagerstown Wash. co. Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 12. Name David S. Fisher
 13. Birthplace Hagerstown Md.
 14. Maiden name Jeanette Alexander
 15. Birthplace Hagerstown Md.

16. Informant Mrs. Katherine E. Berkson
 Address Chicago Ill.
 17. Burial Date thereof 7/9/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md

19. July 9 48 Registrar Phyllis Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION ED 37 A20. DATE OF DEATH July 7 1948 19... at 8.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 19... to 19...
 and that I last saw him alive on 19...

Immediate cause of death Chemical necrosis of esophagus and trachea
 DURATION

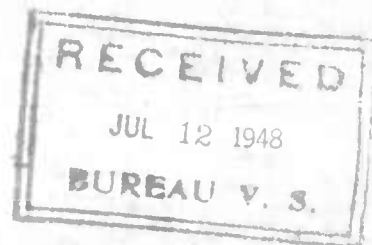
Due to Bilateral chemical pneumonia
 (Draino)

Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op. July 7-48
 Autopsy results As above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Suicide Date of 7/4/48
 Where did injury occur? Hagerstown Wash. Md.
 (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) Home
 Means of injury Drank Draino Injured at work? No

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAM.
 Address Hagerstown, Md WASH. CO., MD.
 Date signed 7/9/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 117 SEP -2 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

07601

302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution?

17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 E. Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alfred. W. Baer

3. (b) Social Security Number

4. Sex

M.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Myra M. BaerB.(c) If alive, give age 58 years

7. Birth date of

deceased (mo., day, yr.)

Sept 8 - 1880

8. AGE:

Years

Months

Days

If less than one day

67 58113

hrs.

min.

9. Birthplace

Mowersville Pa.

(Town, county, and state)

10. Usual occupation

Store Mgr

11. Industry or business

FATHER

12. Name

William A. Baer

13. Birthplace

Mowersville Pa.

MOTHER

14. Maiden name

Esther C. Baer

15. Birthplace

Lurgan Pa.

16. Informant

Mrs. J. D. Baer

Address

105 E. Washington Hagerstown

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 14 - 48

Cemetery or crematorium

Springhill

Location

Shippensburg Penna

18. Funeral director

W. G. B. B. B.

Address

Shippensburg Pa.

19.

(Date rec'd by registrar)

19

Blatt-Bowers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 - 48 at 2:48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19....., to.....19.....

and that I last saw him.....alive on.....7 - 11.....19.....48.....

Immediate cause of death

DURATION

Six months

Due to

Sarcoma of the liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Sarcoma of liver

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Margaret Miller, M.D.

M. D. or other

Address

Hagerstown Md.

Date signed

7 - 11 - 48

RECEIVED

JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....Washington
 City or town.....near Smithsburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

near Smithsburg

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Pennsylvania County.....Franklin

City or town.....Waynesboro
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....Route #4
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME

Oscar Thomas Baker

3.(b) Social Security Number

173-03-3284

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Widower

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....May 27 1889

8. AGE: Years.....59 Months.....1 Days.....13 It less than one day..... hrs. min.

9. Birthplace.....Springfield, Ohio
 (Town, county, and state)

10. Usual occupation.....Cook
 11. Industry or business.....White Swan Tavern

FATHER 12. Name.....Upton Sinclair Baker
 13. Birthplace.....Springfield Ohio

MOTHER 14. Maiden name.....Susie Minnich
 15. Birthplace.....unknown

16. Informant.....Claude E Baker
 Address.....Rouzerville, Penna

17. Burial Date thereof.....7-12-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Locust Valley Cemetery
Burkittsville Maryland
 Location.....

18. Funeral director.....C.M. Suter and Sons
 Address.....Hagerstown Maryland

19. July 12 48 J.W. Ferguson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION about EDT

20. DATE OF DEATH.....July 9 1948 19.....8:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death.....

DURATION

Due to.....Avulsion of skull
hemorrhage & shock

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....Accident Date.....July 9 '48

Where did injury occur?.....Smithsburg Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....W. Md. RR Track

Means of injury.....Struck by train Injured at work?

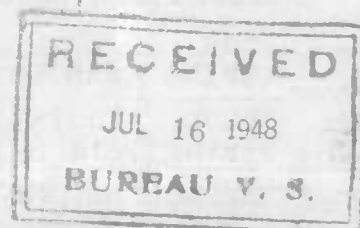
DEPUTY MEDICAL EXAM.

WASH. CO., MD.

23. SIGNATURE.....

M. D. or other

Address.....Waynesboro, Md. Date signed.....July 10 '48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07603

302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
235 Summit Avenue.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 235 Summit Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3.(a) FULL NAME

John William Bazel

3.(b) Social Security Number

217-18-7148

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 8.(b) Name of husband or wife
 8.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 11, 1877
 8. AGE: Years 71 Months 1 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace Downsville, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Painter

11. Industry or business

12. Name Mose Bazel

13. Birthplace Rockingham Co. Virginia

14. Maiden name Ann M. Criswell

15. Birthplace Keedysville, Maryland

16. Informant Mr. Harry Avey

Address 235 Summit Ave. Hagerstown, Md

17. Burial Date thereof Aug. 3, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fairview Cemetery.

Location Keedysville, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland.

19. Aug 2, 1948 66 East Beaver
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1948 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 26 July 1948, to 31 July 1948, and that I last saw him alive on 30 July 1948.

Immediate cause of death Carcinoma of liver DURATION 6 mos.

Due to

Due to

Other conditions Hypertensive pneumonia 3 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

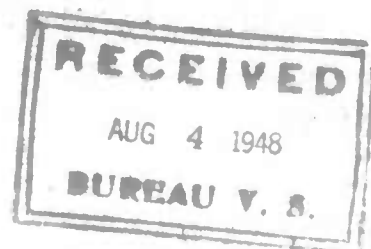
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldon H. Wacklin M. D. or other

Address Hagerstown Date signed 7/31/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07604

78 306

1. PLACE OF DEATH:

County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month 15 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? same

3. (a) FULL NAME

Alice Letha Becker

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Henry Becker

7. Birth date of deceased (mo., day, yr.)

July 12, 1876

6. (c) If alive, give age..... years

8. AGE:

72

Years

Months

Days

If less than one day

1

hrs.

min.

9. Birthplace

Carroll Co., Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Valentine J. Harmon

13. Birthplace

Lyons

14. Maiden name

Elvira Miller

15. Birthplace

Frederick Co., Md.

16. Informant

Mrs. Sarah E. Snyder

Address

Littlestown, Pa.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 16, 1948

(month) (day) (year)

Cemetery or crematory

Lutheran

Location

Taneytown, Md.

18. Funeral director

C. O. FUSS & SON

Address

Taneytown, Md.

19.

July 16, 1948

(Date recd by registrar)

48 Ethel M. McHenry

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Carroll

City or town

Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

none

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 13

19

48 at 1039

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 28

19

48 toJuly 5

19

48

and that I last saw him alive on

July 5

19

48

Immediate cause of death

Malignant tumor of thymus
path. type undetermined

DURATION

about 9 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. M. Armstrong, M.D.

M. D. or other

Address

Ritchie Hospital
Cascade, Md.Date signed 7/13/48

RECEIVED

JUL 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:

County WashingtonCity or town Downsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yearsHospital, institution, or street address where death occurred:
Williamsport, Md. RFD#1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Downsville
(If outside city or town limits, write RURAL and give nearest town)Street No. Williamsport, Md. RFD#1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Annie L. Bowers

3.(b) Social Security Number

NONE

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
-------------------------	----------------------------------	--

B.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept. 12, 18868. AGE: Years Months Days If less than one day
61 10 4 hrs. min.9. Birthplace Near Downsville, Wash., Maryland
(Town, county, and state)10. Usual occupation House Maid11. Industry or business House work12. Name Andrew B. Bowers13. Birthplace Washington County, Maryland14. Maiden name Margaret Lynch15. Birthplace Washington County, Maryland16. Informant Mrs/Sallie E. ShankAddress Williamsport, Md. RFD#117. Burial Date thereof July 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bakersville CemeteryLocation Bakersville, Md.18. Funeral director Mrs Edith V. LeafAddress Williamsport, Md.19. July 17, 1948 E. L. McElroy
(Date read by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1948 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
May 10, 1948 to July 16, 1948and that I last saw her alive on July 17, 1948

Immediate cause of death

DURATION

Carcinoma of uterus 4 mos.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

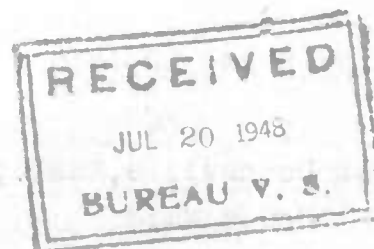
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Sto. J. BineenAddress Williamsport Md Date signed 7/17/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Cohen

07606

Reg. Dist. No. 308 303

1. PLACE OF DEATH:

County Washington
 City or town Clearspring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 11 yrs.
 Hospital, institution, or street address where death occurred:
Broadfording Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Clearspring Route #1
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Broadfording Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

John Jay Charles

3. (b) Social Security Number

214-09-2069

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife -----
 7. Birth date of deceased (mo., day, yr.) March 31, 1899
 8. AGE: Years 49 Months 3 Days 29 If less than one day hrs. min.

9. Birthplace Charles Mill, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Active

12. Name John Charles

13. Birthplace Charlton Md.

14. Maiden name Susan Carr

15. Birthplace Belaire Md.

16. Informant Clark Charles

Address Clearspring Md.

17. Burial Date thereof 7-12-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location Route #40 Western Pike Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. July 10 19 48 Joseph W. Murray
 (Date registered by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 48 at 1:30 M A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from FEB. 25, 1942 19 48 to JULY 10 19 48

and that I last saw him 1M. alive on JULY 10, 1948 19 48

Immediate cause of death XXXX

HYPERTENSIVE CARDIAC DISEASE

CARDIAC DILATATION ACUTE

XXXX

Due to XXXX

Due to XXXX

Other conditions XXXX

(Include pregnancy within 3 months of death)

Major findings of operations None.

Date of op. ---

Autopsy results None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

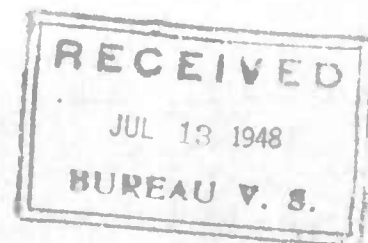
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury --- Injured at work?

23. SIGNATURE Richard Robert Cohen M. D. ---

Address Clear Spring, Md Date signed 7-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Zimmerman

07607

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 weeks
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Sharpsburg Pike
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

Mrs. Sophie S. Cooper

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Fay C. Cooper
 6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1885
 8. AGE: Years 62 Months 6 Days 23 If less than one day
 hrs. min.

9. Birthplace Dry Run, Wash. Cty., Md.
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry Own home

12. Name Scott Seibert
 13. Birthplace Clearspring, Md.
 14. Maiden name Virginia Seibert
 15. Birthplace Clearspring, Md.

16. Informant Fay C. Cooper
 Address Hagerstown, Md.

17. Burial Date thereof 7-25-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St. Paul's Cemetery
 Location Clearspring, Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown, Md.

19. July 25 19 48 Death Review
 Date rec'd by registrar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23, 1948 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1948 to July 23, 1948
 and that I last saw him alive on July 23, 1948
 Immediate cause of death Cerebral hemorrhage DURATION 22 hours

Other conditions Cerebral ischemia 2 yrs
 Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Dr. Zimmerman M. D. or other
 Address Wellspring, Md. Date signed 7/27/48

RECEIVED

JUL 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH USING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07608

301

1. PLACE OF DEATH:

County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

23 West Church St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 23 West Church St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mary Elizabeth Cramer

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband or wife William Cramer

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

May 15, 1866

8. AGE:

Years

Months

Days

If less than one day

82214

hrs.

min.

9. Birthplace Near Williamsport, Wash., Maryland
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name

John Spigler

13. Birthplace

Near Williamsport, Md.

MOTHER

14. Maiden name

Annie Farrow

15. Birthplace

Near Williamsport, Md.

16. Informant

Mrs. Harry Shank

Address

23 West Church St.
Williamsport, Md.17. BurialDate thereof July 31, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Pauls Cemetery

Location

Western Pike Near Clearspring, Md.

18. Funeral director

Edith V. Leaf

Address

Williamsport, Md.19. July 31, 1948

(Date rec'd by registrar)

E Lee McElroy

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29-48 19 12:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-1-48 19 7-29-48 19and that I last saw him alive on 7-29-48 19

Immediate cause of death

Coronary Vascular Disease

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address Williamsport, Md. Date signed 7/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 301

I. PLACE OF DEATH:

County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
Alley Rear of Murray's Restaurant
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Williamsport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 201 S. Artizan
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Harry Barnes Davis Jr.

3. (b) Social Security Number

None

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Single
-----------------------	----------------------------------	---

6. (b) Name of husband or wife
 6. (c) If alive, give age years
 7. Birth date of deceased (mo., day, yr.) August 27, 1942
 8. AGE: Years Months Days It less than one day
5 10 18 hrs. min.

9. Birthplace Williamsport, Wash., Maryland
 (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
 12. Name Harry Barnes Davis
 13. Birthplace Hopewell, Maryland
MOTHER
 14. Maiden name Elinor Joyce Houser
 15. Birthplace Shepherdstown, W. Va.

16. Informant Mrs. Harry Barnes Davis
 Address 201 S. Artizan St. Williamsport, Md.

17. Burial Date thereof July 18, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greenlawn Cemetery
 Location Williamsport, Md.

18. Funeral director Mrs. Edith V. Leaf
 Address Williamsport, Md.

19. July 17, 1948 E. Lee McElroy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1948 6:15 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from E.D.T.
 19..... to 19.....
 and that I last saw him alive on 19.....

Immediate cause of death Fractured skull
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/15/48

Where did injury occur Williamsport, Wash. Md.
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Rear of Murray's Restaurant
 Means of injury Concrete table fell on head

DEPUTY MEDICAL EXAM.
S. Robert Kelly WASH. CO., MD.
 M. D. None

23. SIGNATURE

Flagerstown, Md. Date signed 7/17/48

RECEIVED

JUL 20 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

07610

305

302

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Brethedsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Months
 Hospital, institution, or street address where death occurred:
Md. State Reformatory for Males
 How long in hospital or institution? 6 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester
 City or town East New Market
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war None

3. (a) FULL NAME

GRANVILLE DEMBY

3. (b) Social Security Number

None

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single
 6. (b) Name of husband or wife --
 7. Birth date of deceased (mo., day, yr.) April 18, 1920 6. (c) If alive, give age -- years
 8. AGE: Years 28 Months 3 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace East New Market, Dorchester Co.
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name James Bently
 13. Birthplace E. New Market Md.
 14. Maiden name Sarah Farrare
 15. Birthplace E. New Market Md.

16. Informant Jerome Frampton
 Address Federalburg Md.

17. Burial Date thereof 7/31/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory New Market Cemetery
 Location East New Market, Dorchester Co. Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. July 29, 1948 John H. East
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28, 1948, at _____ M

21. I CERTIFY the death occurred on the date above stated; that I attended deceased from June 1, 1948 to July 28, 1948
 and that I last saw him alive on July 28, 1948

Immediate cause of death _____

DURATION

Pulver. Tuberculosis 1 yr
Md.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert P. Conrad M.D. M. D. of other _____

Address Hagerstown, Md. Date signed 7-29-48

RECEIVED

AUG 2 1948

BUREAU V. S.

PLEASE, WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
 City or town Cascade
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 months 18 days
 Hospital, institution, or street address where death occurred: Ketchum Hospital
 How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles
 City or town Bryans Road
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Margaret Audreace Downs

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced widowed
 6. (b) Name of husband or wife Thomas F. Downs
 7. Birth date of deceased (mo., day, yr.) Sept 30, 1883
 6. (c) If alive, give age _____ years
 8. AGE: Years 64 Months 9 Days #13 If less than one day _____ hrs. _____ min.

9. Birthplace Nova Scotia
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business _____

12. Name Frederick Pratt

13. Birthplace Nova Scotia

14. Maiden name Jane E. Dickson

15. Birthplace Nova Scotia

16. Informant Mrs. J. N. Metcalfe Daughter

Address Bryans Road Md

17. Burial Date thereof 7-5-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Shilo

Location Bryans Road Md

18. Funeral director Hunter & Gray

Address Waldorf Md

19. 7-5-48 M. L. Howard
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 19 48, at 2 A. M.

21. I CERTIFY that death occurred on the date above elated; that I attended deceased from Jan 16 19 48, to July 3 19 48

and that I last saw him alive on July 2 19 48

Immediate cause of death Bronchial asthma + Pulmonary emphysema

DURATION 4 yrs

Due to _____

Due to _____

Other conditions Hypertrophic arthritis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

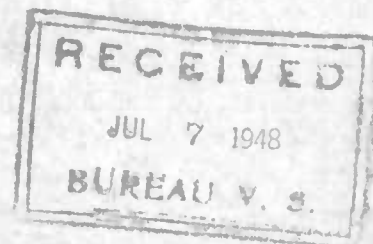
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Thomas M. Arington, M.D.

Address Ketchum Hosp. Cascade Md. Date signed 7/3/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07612

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 41 North Potomac Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Eileen Virginia Drennen

3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife 6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1892

8. AGE: Year Month Days If less than one day
56 3 19 hrs. min.

9. Birthplace Clearspring, Maryland
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business Welfare Board

12. Name Thomas Drennen
13. Birthplace Clearspring, Maryland

14. Maiden name Margaret Wells
15. Birthplace Martinsburg, W. Va.

16. Informant Mrs. Mary Fink
Address Hagerstown, Maryland

17. Burial Date thereof 7-17-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons
Address Hagerstown, Maryland

19. July 16, 48 Registrar
(Date registered by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14, 1948 at 8:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 11, 1948 to July 14, 1948
and that I last saw him alive on July 14, 1948

Immediate cause of death

Peritonitis

Due to mesenteric thrombosis of ileum

Due to Resection of ileum

Other conditions Resection of ileum

(Include pregnancy within 3 months of death)

Major findings of operations Thrombosis of mesenteric artery - Date of op. June 11-48

Autopsy results not permitted
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Suter, M.D. M. D. or other
Address Hagerstown, Md. Date signed 7/16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUL 19 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The street age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07613
306

1. PLACE OF DEATH:

County Washington
 City or town Cascade
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months 4 days
 Hospital, institution, or street address where death occurred Pitche Hospital
 How long in hospital or institution? same

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard
 City or town Duckett Lane
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Charles Alexander Duckett

3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Bessie G. Duckett

7. Birth date of deceased (mo., day, yr.)

Dec 13 1890

6. (c) If alive, give age

52 years

8. AGE:

Years

Months

Days

If less than one day

67716

hrs.

min.

9. Birthplace

Charles County, Md.
(Town, county and state)

10. Usual occupation

no record

11. Industry or business

MOTHER FATHER

12. Name

Joseph Duckett

13. Birthplace

Charles County

14. Maiden name

Brawley

15. Birthplace

Charles County

16. Informant

Mrs. Bessie G. Duckett

Address

Elkridge, Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

Aug. 3 1948
(month) (day) (year)

Cemetery or crematory

Mt. Zion

Location

Baltimore, Md.

18. Funeral director

Mrs. George A. Halland

Address

1631 Reginald Hill Ave.

19.

(Date rec'd by registrar)

Aug. 3 48a. w. Hedrick
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 2919 48at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 25 1948 to July 29 1948and that I last saw him alive on July 29 1948

Immediate cause of death

Mass intestinal hemorrhageprobable carcinoma of colon

Due to _____

Due to _____

Other conditions Fistula between colon + left - 2 renal calculi

(3) Perineal sinus (Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results Pyelonephritis, calculi, perineal sinus, fecal fistula

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, pub'c place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE T. M. Crumpton, M.D.
M. D. or other _____Address Pitche Hospital, Cascade, Md. Date signed 7/29/48

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

Birth & Death
 Reg. Dist. No. 159 01014

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
 City or town Hagerstown, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Washington County Hospital
 Length of mother's stay in County 61 yrs.
 (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Washington
 City or town Route 5 Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Leettersburg
 (If RURAL give LOCATION)

3. Name of child

5. Sex male 6. Twin or triplet

4. Date of birth July 11, 1948 Hour 5:46 A.M.

7. No. of weeks pregnancy 22-24

FATHER OF CHILD

8. Full name Berry Emmett Edwards Jr.
 9. Color W 10. Age at time of this birth 20 yrs.
 11. Usual occupation Truck Driver

MOTHER OF CHILD

12. Full maiden name Ruth Joyce Peiffer
 13. Color W 14. Age at time of this birth 21 yrs.
 15. Usual occupation Student Nurse

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? None
 (b) How many other children were born alive but are now dead? None (c) How many other children were born dead? None

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of None apparent

19. Labor: (a) Complications of none
 (b) Induced? ?

20. (a) Was there an operation for delivery? No
 (Yes or No)

(b) State all operations, if any None

(c) Did child die before operation? —
 During operation? —

23. (a) Cremation (b) Date thereof July 22, 1948
 (Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Crematory

24. (a) Funeral director None

(b) Address —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes Prematurity
 (b) Maternal causes Induction suspected

22. I certify to the birth of this child who was born dead* on the date and hour above stated.

Signature Robert J. Icard MD
 (Specify if M. D., midwife, or other)

Address 132 W. Wash St. Hagerstown, Md.

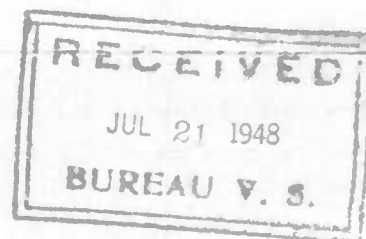
25. (a) July 19, 1948 (b) Berry Edwards
 Date rec'd by registrar (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per

* See Instruction C on stub.

Gasped several times
 3 midw.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH:

County... Washington

City or town... Clear Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... Washington

City or town... Clear Spring
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Celia M. Eichelberger

3. (b) Social Security Number

None

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife... Alexander Eichelberger

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1860

8. AGE: Years 87 Months 10 Days 3 If less than one day hrs. min.

9. Birthplace... Washington Co. Md.
(Town, county, and state)

10. Usual occupation... Home Duties

11. Industry or business

12. Name... John Kline

13. Birthplace... Md.

14. Maiden name... Unknown

15. Birthplace

16. Informant... Mrs. John Kelley

Address... Clear Spring, Md.

17. Burial Date thereof... July 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... St. Pauls Cemetery

Location... Clear Spring, Md.

18. Funeral director... Snyder-Rowland

Address... Hancock, Md.

19. July 28, 48 Joseph W. Murray
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 25, 48 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 38, to July 25, 48 and that I last saw him alive on July 25, 48.

Immediate cause of death... Coronary occlusion acute DURATION 5 hrs.

Due to... Hypertension cardio-vascular and disease ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations... None.

Date of op. ...

Autopsy results... none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Anti Robert Cohen M. D. over

Address... Clear Spring Md. Date signed 7-27-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS/A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

OCT 5 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1246

07615

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Boonsboro
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Guilford Convalescent Home
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wash.
 City or town Keedysville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Oscar W. Grossnickel

3.(b) Social Security Number

none

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife _____ 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Oct. 10, 1867
 8. AGE: Years 80 Months 8 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Keedysville, - Wash. - Md.
 (Town, county, and state)
 10. Usual occupation Wheel Wright
 11. Industry or business Self
 12. Name John A. Grossnickel
 13. Birthplace Frederick County
 14. Maiden name Mary Tracey
 15. Birthplace Washington County

18. Informant Miss Mary Grossnickle
 Address Keedysville, Md

17. Burial July 5, 1948
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
 Cemetery or crematory Fair-View
 Location Keedysville, Md

18. Funeral director R. I. Earnshaw
 Address Keedysville, Md

19. July 3, 1948 John H. Bass
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 2 19 48, at 7:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1948 to July 2, 1948
 and that I last saw him alive on July 2, 1948

Immediate cause of death Coronary Thrombosis
Arteriosclerosis of heart
Artificial Vly. prosthesis
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

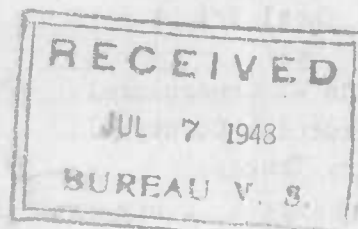
23. SIGNATURE John H. Bass M. D. or otherAddress Boonsboro, Md. Date signed 7/3/48

DURATION

3 hours.

1 hr. 12 days

1 hr. 32 days



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07616

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
 City or town Forest Grove - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
Robersville Md. R.I.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Forest Grove - Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Robersville Md. R.I.
 (If rural, give LOCATION)
 2. (a) If veteran, name war no.

3. (a) FULL NAME

Fannie Stella Haynes

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife J. W. Haynes 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July - 6 - 1878
 8. AGE: Years 70 Months 0 Days 3 If less than one day _____ hrs. _____ min.

9. Birthplace Sandy Hook Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business Own Home
 12. Name John W. Field
 13. Birthplace Virginia
 14. Maiden name Susan Stine
 15. Birthplace Wash. Co. Md.

16. Informant J. W. Haynes
 Address Robersville Md. R.I.
 17. Burial Date thereof July 11 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mt. Zion Cemetery
 Location Forest Grove Md.
 18. Funeral director Wm. J. Bart & Son
 Address Boonsboro Md.

19. July 10 1948 Mrs. Katherine Depue
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 9 - 1948 at 12:45 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22 1948 to July 9 1948
 and that I last saw him alive on July 6 1948
 Immediate cause of death _____

Due to Chronic Myocarditis -
Bronchitis
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE GW Petty M. D. or other _____
 Address Boonsboro Date signed 7/9/48

RECEIVED
JUL 13 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Wells

07617

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 min.
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown Md. St.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 410 Freemont St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

HERBERT LINWOOD HERRALL

3. (b) Social Security Number

219-20-4478

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Thelma Price
 7. Birth date of deceased (mo., day, yr.) July 1 1888 6. (c) If alive, give age 29 years
 8. AGE: Years 60 Months 6 Days 7 If less than one day hrs. min.

9. Birthplace Shepherdstown Jefferson Co. W. Va.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business --

MOTHER FATHER
 12. Name No. Record
 13. Birthplace No Record
 14. Maiden name No Record
 15. Birthplace No Record

16. Informant Raymond L. Herrall
 Address Kearneysville W. Va.

17. Burial Date thereof 7/17/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Salem Lutheran cemetery
 Location Bakersville Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. July 16, 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1948 at 1:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death Acute coronary occlusion

DURATION

Due to the of lungs
 Due to None
 Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

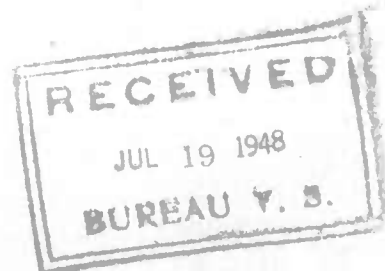
Accident, suicide, or homicide None Date of None

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Richard Wells DEPUTY MEDICAL EXAM
Hagerstown Md. WASH. CO., MD.
 Date signed 7/16/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 8 hours

Hospital, institution, or street address where death occurred:

Wash Co. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Rural - Hancock
(If outside city or town limits, write RURAL and give nearest town)Street No. Route #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Ray Samuel Hoffmann

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Ilda GenevieveShepard7. Birth date of deceased (mo., day, yr.) May 6, 19166.(c) If alive, give age 27 years

8. AGE: Years Months Days If less than one day

32 2 21 hrs. min.9. Birthplace Sleepy Creek, Morgan Co., W. Va.

(Town, county, and state)

10. Usual occupation Labarer

11. Industry or business

12. Name Samuel H. Hoffmann13. Birthplace Morgan Co., W. Va.14. Maiden name Katie G. Gantt15. Birthplace Morgan Co. W. Va.16. Informant Mrs. Ray HoffmannAddress Route #1, Hancock, Md.17. Burial Date thereof July 30, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Evangelical ChurchLocation Sports Crossroads, W. Va.18. Funeral director Charles R. BastAddress Hancock, Md.19. July 30 48 Registrar John Veller

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 July 1948, at 4:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17 Jan 1948, to 27 July 1948and that I last saw him alive on 27 July 1948Immediate cause of death Acute Encephalomyelitis

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Eldon D. H. Vonderhede M. D. or otherAddress Hancock, Md. Date signed 7/28/48

RECEIVED

AUG - 2 - 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07619

302

131a

1. PLACE OF DEATH:

County..... Washington
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... Life
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution?..... 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 45 West Side Avenue
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME

Ida May Huffman

3. (b) Social Security Number

None

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married
6. (b) Name of husband or wife..... Howard W. Huffman
7. Birth date of deceased (mo., day, yr.)..... Nov. 17, 1893
6. (c) If alive, give age..... years
8. AGE: Years..... 54 Months..... 7 Days..... 14 If less than one day..... hrs. min.

9. Birthplace..... Hagerstown, Wash. Co., Md.
(Town, county, and state)
10. Usual occupation..... Home Duties
11. Industry or business.....
12. Name..... Nathan D. Monninger
13. Birthplace..... Washington County Md.
14. Maiden name..... Martha E. Shank
15. Birthplace..... Washington County Md.

16. Informant..... Howard W. Huffman
Address..... 45 West Side Ave. Hagerstown, Md.
17. Burial..... Burial Date thereof..... July 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Rose Hill Cemetery
Location..... Hagerstown, Maryland
18. Funeral director..... Fred W. Kraiss
Address..... Hagerstown, Maryland.

19. July 4, 1948 Registrar..... Charles Bowers
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 1, 1948 6:52 P.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11, 1948 to July 1, 1948
and that I last saw him/her alive on July 1, 1948
Immediate cause of death..... Myocardial Infarction DURATION..... 1 hr.
Due to..... arteriosclerotic heart disease 1 hr.
Due to..... arteriosclerotic heart disease 1 day
Other conditions..... of chronic 1 day
(Include pregnancy within 3 months of death)
Major findings of operations..... None
Date of op.....
Autopsy results..... No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... X Date of..... X
Where did injury occur?..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury..... Injured at work?
23. SIGNATURE..... W. Howard Dykes M. D. or other
Address..... Hagerstown Md. Date signed..... July 2, 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07620

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred:

21 E. Baltimore St.

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 E. Baltimore St.

(If rural, give LOCATION)

non-vet

2.(a) If veteran, name war -

3. (a) FULL NAME

MATTIE MAY JUDD

3. (b) Social Security Number

none

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female

White

Married

6.(b) Name of husband or wife Joseph D. Judd

6.(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) February 11, 1890

8. AGE: Years Months Days If less than one day
58 4 28 hrs. min.

9. Birthplace Luray, Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph D. Racer

13. Birthplace Luray, Virginia

14. Maiden name Laura Belle Rowe

15. Birthplace Luray, Virginia

16. Informant Joe D. Judd

Address 21 E. Baltimore St

17. Burial Date thereof 7/14/48

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Beahm's Chapel Cemetery

Location Luray, Virginia

18. Funeral director W. T. Norment

Address Hagerstown, Maryland

19. Date rec'd by registrar July 12, 1948

Registrar Phyllis Powers

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 19 48 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

July 1947 19 48 to July 11 19 48

and that I last saw him alive on 11 July 19 48

Immediate cause of death Cerebral Hemorrhage

DURATION

10 Hrs.

Due to Arthritis Chronic. severs

Due to 20 yrs.

Other conditions Arthritis Chronic. severs

(Include pregnancy within 3 months of death)

Major findings of operations -

Date of op. -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Edna H. Washburn

M. D. or other

Address Hagerstown

Date signed 7/12/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF TITRATION

RECEIVED

JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07621
386

1. PLACE OF DEATH:

County Washington
 City or town Rural Smithsburg #2
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 74 yrs
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Washington
 City or town Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Smithsburg Md, #2
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mary Alice Justice

3.(b) Social Security Number

4. Sex

F.

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

W.

6.(b) Name of husband or wife

Martin Justice

7. Birth date of

deceased (mo., day, yr.)

Sept. 17, 1853

5.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

94100hrs.min.

9. Birthplace

Near Smithsburg Md.
(Town, county, and state)

10. Usual occupation

House Duties

11. Industry or business

MOTHER FATHER

12. Name

Jacob Stouffer

13. Birthplace

Wash Co. Md

14. Maiden name

Elizabeth Gehr

15. Birthplace

Wash Co. Md.

16. Informant

Mrs D M. Ridenour

Address

Smithsburg Md. #2

17.

(Burial, cremation, or removal, Which?)

Date thereof

7/20/48
(month) (day) (year)

Cemetery or crematory

Stouffer Cemetery

Location

Smithsburg Md #2

18. Funeral director

Walter J. Grove

Address

27 S. Church St., Waynesboro Pa

19.

(Date rec'd by registrar)

July 19, 1948Her W. Ferguson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 17, 1948, at 1:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13, 1948, to July 17, 1948

and that I last saw him alive on

July 17, 1948

Immediate cause of death

Pulmonary artery Edema 24 hrs

DURATION

Due to

Cerebral infarct - 5 days 12 hrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E G T Oiler

M. D. or other

Address

Smithsburg Md

Date signed

7/19/48

WESTERN STATE DEPARTMENT OF HEALTH

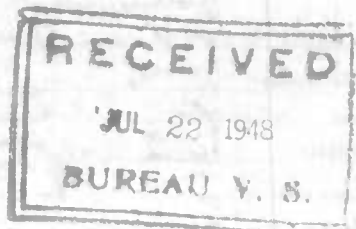
CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. DATE OF BIRTH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Welty

46P

07622

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Weeks

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 5 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County MorganCity or town Berkley Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

James Offie Kave

3. (b) Social Security Number

231-03-8503

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Myrtle Kave

7. Birth date of

deceased (mo., day, yr.)

July 3, 18916. (c) If alive, give age 48 years

8. AGE:

Years

57

Months

0

Days

27

If less than one day

hrs.

min.

9. Birthplace Spring Gap, Allegany Co., Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

Robert Lee Kave

13. Birthplace

Luray Va.

MOTHER

14. Maiden name

Fannie Herrell

15. Birthplace

Luray Va.

16. Informant

Mrs Myrtle Kave

Address

Berkley Springs W. Va.

17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof 8/2/48

(month) (day) (year)

Cemetery or crematory

Green Way Cemetery

Location

Berkley Springs, Morgan Co., W.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

(Date rec'd by registrar)

19.

48Chas. H. Powers

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 48 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 7 19 48, to July 30 19 48.and that I last saw him alive on July 30 19 48.

Immediate cause of death

Obstructive Jaundice

DURATION

4 months

Due to

Biliary Cirrhosis3 months

Due to

Carcinoma of Hepatic Duct?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma - Biliary Cirrhosis

Date of op.

Autopsy results

Carcinoma, Hepatic Duct; Biliary Cirrhosis

PHYSICIAN: Please underline the cause to which death should be charged statelically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

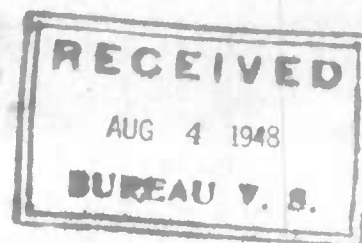
23. SIGNATURE

Salmon M. Welty

M. D. or other

Address

Hagerstown, MarylandDate signed 8-2-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown 216 N. Cannon
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 34 yrs.
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 216 N. Cannon ave.
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Lillian M. King

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Howard J. King

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Mar. 4th 1877

8. AGE:

Years

Months

Days

If less than one day

7147

hrs.

min.

9. Birthplace

Utica N. Y.

(Town, county, and state)

10. Usual occupation

Home keeper

11. Industry or business

FATHER

12. Name

Erran Barber

13. Birthplace

Paris Hill N. Y.

MOTHER

14. Maiden name

Anneling Becraft

15. Birthplace

Paris Hill N. Y.

18. Informant

Mrs. Roy R. Rider

Address

216 N. Cannon ave. Hagerstown Md.

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

7/14/48
(month) (day) (year)

Cemetery or crematory

West Haven Cemetery

Location

Hagerstown Md.

18. Funeral director

O. L. Luman Co.

Address

Hagerstown Md.

19. July 14, 1948

(Date registered by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 11 - 48 19 at 2:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-48 19 to 7-11-48 19and that I last saw him alive on 7-8-48 19

Immediate cause of death

Chr. Myocarditis

DURATION

4 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

EW Luman

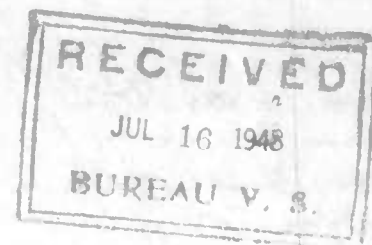
M. D. or other

Address

Hagerstown Md.

Date signed

7/14/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
431 West Church St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 431 West Church Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Carrie May Kretzer3. (b) Social Security Number
None

4. Sex Female 5. Color or race White 6. (a) Single, married, or divorced Single
 6. (b) Name of husband or wife
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) July 21, 1881
 8. AGE: Years 67 Months 0 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Maryland
 (Town, county, and state)
 10. Usual occupation Home Duties
 11. Industry or business
 12. Name Albert Kretzer
 13. Birthplace Maryland
 14. Maiden name Catherine Ridenour
 15. Birthplace Maryland

16. Informant Mrs. Roy Snook
 Address 935 Spruce Street, Hagerstown, MD.
 17. Burial Date thereof JULY 26, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory SHILOAH CEMETERY
 Location Fiddlesburg, Maryland.
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland.

19. July 26, 1948 Registrar Charles Bowers
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 23 July 1948 at 10 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 July 1948 to 23 July 1948
 and that I last saw him or her alive on 23 July 1948
 Immediate cause of death Cerebral Hemorrhage
 DURATION 3 days
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE J. J. Lusby M. D. or other _____
 Address 2301 P. Street Date signed 26 July 48

RECEIVED

JUL 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

183

07625

Reg. Dist. No. 307

1. PLACE OF DEATH:

County WashingtonCity or town _____
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Drowned in Potomac river nearHow long in hospital or institution? Dargun, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 256 S. Locust Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War No. 1

3. (a) FULL NAME

Charles B. Kridler

3. (b) Social Security Number

217-10-3101

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Margaret L. Kridler

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

March 21, 1901

8. AGE:

Years

Months

Days

If less than one day

47318

hrs.

min.

9. Birthplace Hagerstown, Maryland

(Town, county, and state)

10. Usual occupation Silk weaver - Southern Ribbon Co.

11. Industry or business

12. Name Harvey R. Kridler13. Birthplace Hagerstown, Maryland14. Maiden name Ida V. Chapman15. Birthplace Virginia16. Informant Mrs. Margaret L. KridlerAddress 256 S. Locust St. Hagerstown, Md.17. Burial Date thereof July 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director Fred W. KraissAddress Hagerstown, Maryland19. July 13, 1948 Mrs. Katherine Hagenhart
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

July 10 '48 about EDT1:55P M

20. DATE OF DEATH _____ 19 _____ 21 _____

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

_____ 19 _____, to _____ 19 _____

and that I last saw h. _____ alive on _____ 19 _____

Immediate cause of death

DURATION

Suffocation by drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of July 9 '48Where did injury occur? Near Dargun Wash. Md.
(City or town) Potomac RiverInjured at home, farm, industry, public place (where?) boat turned over in River No
Means of injury boat turned over in River No

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

23. SIGNATURE

St. Robert Mills Hagerstown, Md. July 12 '48
Address Date signed

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The contents of this page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07626
307

1. PLACE OF DEATH:

County... WashingtonCity or town... Williamsport
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifetimeHospital, institution, or street address where death occurred:
133 N. Artizan St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 133 N. Artizan St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mary Motter Lemen

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
<u>Female</u>	<u>White</u>	<u>Single</u>

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 9, 1882

8. AGE:	Years	Months	Days	If less than one day
	<u>66</u>	<u>1</u>	<u>7</u>hrs.min.

9. Birthplace... Williamsport, Wash., Maryland
(Town, county, and state)10. Usual occupation... School Teacher (Retired)11. Industry or business... Public Schools12. Name... Peter Light Lemen13. Birthplace... Maidstone, West Va.14. Maiden name... Nancy Motter15. Birthplace... Williamsport, Maryland16. Informant... Miss Nellie Lemen
Address... 133 N. Artizan St.
Williamsport, Md.17. Burial Date thereof... July 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Riverview CemeteryLocation... Williamsport, Maryland18. Funeral director... Edith V. LeafAddress... Williamsport, Md.19. July 30 19 48 E Lee MCF
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 28 19 48 at 7 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1947 19 48 to July 28 19 48and that I last saw him alive on July 28 19 48

Immediate cause of death

DURATION

Due to... Acute Regurgitation 2 years
myocarditis chronic 2 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. J. M. MCF M. D. or otherAddress... Williamsport Md Date signed 7-29-48

RECEIVED

AUG 3 1948

BUREAU V. S.

(159) *Birth & Death* 302
Reg. Dist. No. 07627

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF ~~STILLBIRTH~~

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street address, hospital, or institution:
Washington County Hospital
Length of mother's stay in County 9 yrs.
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101 W. Bethel Street
(If RURAL give LOCATION)

3. Name of child Baby Girl Lewis

5. Sex female 6. Twin or triplet

4. Date of birth July 17 19 48 Hour 3:00 P.M.

7. No. of weeks pregnancy 6 1/2 months D.S.T.

FATHER OF CHILD

8. Full name Refused to give name
9. Color 10. Age at time of this birth yrs.
11. Usual occupation

MOTHER OF CHILD

12. Full maiden name Lelia Estelle Lewis
13. Color black 14. Age at time of this birth 18 yrs.
15. Usual occupation maid

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 1

17. Did child die before labor? no During labor? no

18. Pregnancy, complications of none

19. Labor: (a) Complications of none
(b) Induced? no

20. (a) Was there an operation for delivery? no

(b) State all operations, if any none
(Yes or No)

(c) Did child die before operation? no
During operation? no

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

(a) Fetal causes prematurity
(b) Maternal causes none

22. I certify to the birth of this child who was born alive on the date and hour above stated. dead

Signature Sidney Hovestetter
(Specify if M. D., midwife, or other)

Address Farmington Md.

23. (a) Cremation (b) Date thereof July 19, 1948
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory Wash. Co. Hosp. Crem.

24. (a) Funeral director Hospital

(b) Address Hagerstown, Md.

25. (a) July 22, 1948 (b) Blair Hovestetter
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
The above certificate has been examined by me.

Health Officer, per.....

* See Instruction C on stub.

Lived 56 3/4 hrs.
(1 day +)

V. S. A10

RECEIVED

JUL 24 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

99

07628

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? life
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Funkstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Naomi G. Lewis

3. (b) Social Security Number

217-10-3097

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Robert F. Lewis
 7. Birth date of deceased (mo., day, yr.) April 26, 1912 6. (c) If alive, give age _____ years
 8. AGE: Years 36 Months 3 Days 1 It less than one day _____ hrs. _____ min.

9. Birthplace Funkstown, Maryland
 (Town, county, and state)
 10. Usual occupation Home duties
 11. Industry or business _____
 12. Name Clarence N. Keller
 13. Birthplace Washington County Maryland
 14. Maiden name Nellie M. Reynold
 15. Birthplace Washington County Maryland

16. Informant Robert F. Lewis
 Address Funkstown, Maryland
 17. Burial Date thereof July 29, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown, Maryland
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland
 19. July 29, 1948 Registrar Phyllis H. Brown
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1948 at 3:30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that it attended deceased from July 21, 1948 to July 27, 1948
 and that I last saw him alive on July 27, 1948
 Immediate cause of death Ruptured intestine =
anastomosis perforating DURATION 18 hrs
 Due to unknown cause,
possibly meaning from ?
 Due to boils
 Other conditions clear 3 days
Pregnancy, 4th term
delivered (no relation to death)
 Major findings of operations (delivered) Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE W. J. Ogman, M.D.
 Address Hagerstown, Md. Date signed 27 July 1948
 M. D. or other

Copied to C.H.

RECEIVED

JUL 31 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County.....
 City or town..... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 25 years
 Hospital, institution, or street address where death occurred:
 Washington County Hospital
 How long in hospital or institution?..... 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 337 West Washington Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3.(a) FULL NAME
 Ralph Eugene Long

3.(b) Social Security Number
 705-12-3639

4. Sex..... Male
 5. Color or race..... White
 6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Helena Long

7. Birth date of deceased (mo., day, yr.)..... March 2, 1874
 8.(c) If alive, give age..... 71 years

8. AGE: Years..... 74 Months..... 4 Days..... 17
 If less than one day..... hrs..... min.

9. Birthplace..... Morrisonville, Virginia
 (Town, county, and state)

10. Usual occupation..... Retired Railroad Engineer

11. Industry or business..... B.&O Railroad

12. Name..... Henry Clay Long

13. Birthplace..... Virginia

14. Maiden name..... Mary Frances Cordell

15. Birthplace..... Virginia

16. Informant..... Mrs. Ralph Long

Address..... Hagerstown, Maryland

17. Burial..... Date thereof..... 7-21-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons

Address..... Hagerstown, Maryland

19. July 20, 48
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 19, 1948 at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1948 to July 19, 1948 and that I last saw him alive on July 19, 1948

Immediate cause of death..... Carcinoma of Prostate Glands
 DURATION..... 10 yrs.

Due to.....

Due to.....

Other conditions..... General Atherosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma of Prostate Glands

Date of op.....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... injured at work?

23. SIGNATURE..... J. H. Bulley M.D.

Address..... Date signed.....

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07630

302

1. PLACE OF DEATH: County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>24 years</u> Hospital, institution, or street address where death occurred: <u>118 E. Franklin St</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>118 E. Franklin St</u> (If rural, give LOCATION) 2.(a) If veteran, name war			
3.(a) FULL NAME <u>George Luman Lowell</u>				3.(b) Social Security Number <u>None</u>			
4. Sex <u>Male</u>		5. Color or race <u>White</u>		6.(a) Single, married, widowed, or divorced <u>Married</u>			
6.(b) Name of husband or wife <u>Winnifred I. Lowell</u>				6.(c) If alive, give age years			
7. Birth date of deceased (mo., day, yr.) <u>Dec. 28, 1859</u>							
8. AGE: Years <u>88</u>		Months <u>6</u>		Days <u>5</u>		If less than one day hrs. min.	
9. Birthplace <u>New Hampshire</u> (Town, county, and state)							
10. Usual occupation <u>Minister</u>							
11. Industry or business							
12. Name <u>Lowell</u>							
13. Birthplace <u>Unknown</u>							
14. Maiden name <u>Unknown</u>							
15. Birthplace <u>Unknown</u>							
16. Informant <u>Mrs. Winifred I. Lowell,</u> Address <u>118 E. Franklin St. Hagerstown,</u> <u>Burial</u> Date thereof <u>July 6, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Rest Haven Cemetery</u> <u>Hagerstown, Md.</u> Location							
19. Funeral director <u>Fred W. Kraiss</u> Address <u>Hagerstown, Md.</u>							
19. <u>July 6, 48</u> <u>Booth Bowers</u> (Date rec'd by registrar) Registrar							
MEDICAL CERTIFICATION							
20. DATE OF DEATH <u>July 3, 1948</u> <u>11:30 P. M.</u>							
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>7-3-48</u> to <u>7-3-48</u> and that I last saw him on <u>7-4-48</u>							
Immediate cause of death <u>Cardio-Vascular Disease</u>						DURATION <u>5 yrs</u>	
Due to							
Due to							
Other conditions							
(Include pregnancy within 3 months of death)							
Major findings of operations							
Date of op.							
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically. <u>Md.</u>							
22. VIOLENCE: If death was due to external causes, fill in the following:							
Accident, suicide, or homicide Date of							
Where did injury occur? (City or town) (County) (State)							
Injured at home, farm, industry, public place (where?)							
Means of injury Injured at work?							
23. SIGNATURE <u>[Signature]</u>							
Address <u>[Signature]</u> Date signed <u>7/4/48</u>							

RECEIVED

JUL 8 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 076315

1. PLACE OF DEATH:

County WashingtonCity or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:

Carlford Nursing HomeHow long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Tennessee County FranklinCity or town Waynesboro
(If outside city or town limits, write RURAL and give nearest town)Street No. 130 West Second St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

3. (a) FULL NAME

John Sheridan Macken

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Widowed

7. Birth date of deceased (mo., day, yr.)

October 1 - 1865

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

82929

..... hrs. min.

9. Birthplace

Baltimore, Md.
(Town, county, and state)

10. Usual occupation

Retired Blacksmith

11. Industry or business

MOTHER

FATHER

12. Name

William M. Macken

13. Birthplace

Grifton W. Va.

14. Maiden name

Isabel Huston

15. Birthplace

Grifton W. Va.

16. Informant

Friends, Carlford Nursing Home

Address

Boonsboro Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

August 2, 1948
(month) (day) (year)

Cemetery or crematory

London Park Cemetery

Location

Baltimore, Md.

18. Funeral director

Walter G. Case

Address

Waynesboro, Tennessee

19.

(Date rec'd by registrar)

July 31, 1948John H. Bost

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1948 at 1:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 5 1948 to July 30 1948and that I last saw him alive on July 30 1948

Immediate cause of death

Heart
Acute dilatative I.P. heart failurearterial hypertension

Due to

General arterio-sclerosis

DURATION

 sudden3 hrs.3 hrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John H. Bost M. D.

M. D. or other

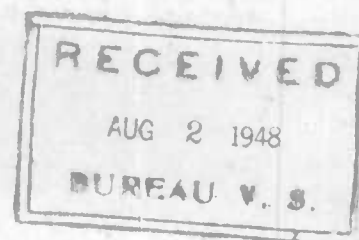
Address

Boonsboro, Md.Date signed 7/30/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 wks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 5 wks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State md County Washington
City or town RD # 6
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

ANNA F. MARTIN

3. (b) Social Security Number

none

4. Sex F 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed
6.(b) Name of husband or wife William C. Martin
6.(c) If alive, give age dead years
7. Birth date of deceased (mo., day, yr.) Aug 12, 1872
8. AGE: Years 75 Months 11 Days 16 If less than one day
hrs. min.

9. Birthplace Franklin Co. R
(Town, county, and state)
10. Usual occupation Hagerstown
11. Industry or business Home
12. Name Jacob Bearhart
13. Birthplace R
14. Maiden name Kathryn Barr
15. Birthplace R

16. Informant William H. Martin
Address Hagerstown RD # 6
17. Burial Date thereof July 30, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematorium Cedar Grove
Location near Greencastle R
18. Funeral director A. E. Spurr
Address Greencastle R
19. July 30, 48 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25, 1948, at 5:50 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23 1948 to 7/28 1948
and that I last saw her alive on 7/27 1948
Immediate cause of death Arteriosclerotic DURATION
Cardio-vascular-renal disease 10 yrs
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE McDewey M. D. or other
Address Greencastle R. Date signed 7/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07633

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
602 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 602 West Washington Street
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Virgie B. Martin

3.(b) Social Security Number

NONE

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Joseph H. Martin
 6.(c) If alive, give age 75 years
 7. Birth date of deceased (mo., day, yr.) August 14, 1880
 8. AGE: Years 67 Months 10 Days 26 It less than one day
 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Alexander

13. Birthplace Hagerstown, Maryland

MOTHER 14. Maiden name Caroline Shilling

15. Birthplace Hagerstown, Maryland

16. Informant Joseph H. Martin

Address Hagerstown, Maryland

17. Burial 7-13-48
 (Burial, cremation, or removal. Which?) Oste thereof (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. July 12 19 48 Chas. H. Bowes
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 10 19 48 at 1:15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 19 48 to July 1 19 48

and that I last saw him alive on July 1 19 48

Immediate cause of death

No physician in attendance

at time. History would

Due to suggests she expired

after convulsion

Due to

Other conditions Chronic epilepsy &

" alcoholism.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Campbell

M. D. or other

Address Date signed

RECEIVED
JUL 14 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07634 801

1. PLACE OF DEATH:

County WashingtonCity or town Rural Dist.
(If outside city or town limits, write RURAL and give nearest town)How long is above place of death? 1 dayHospital, institution, or street address where death occurred:
Charles Mills, Downsville Dist.

How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Virginia County Berkeley Co.City or town Martinsburg, W. Va.
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____ ✓

3.(a) FULL NAME

Lemuel Webster May

3.(b) Social Security Number

212-07-60264. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) February 14, 19088. AGE: Years 40 Months 4 Days 21 If less than one day _____ hrs. _____ min.9. Birthplace Jefferson County, W. Va.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Cement Plant12. Name John Henry May13. Birthplace Jefferson Co. W. Va.14. Maiden name Bessie Williams15. Birthplace Berkeley, Co. W. Va.16. Informant John H. MayAddress Martinsburg, W. Va.17. Burial Date thereof 7-8-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bunker Hill CemeteryLocation Bunker Hill, W. Va.18. Funeral director Howard K. BrownAddress Martinsburg, W. Va.19. July 6 1948 Mrs. E. L. McEwen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5-48 19____ at 9:15 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased on July 6-48 19____ to July 5-48 19____and that I last saw him dead upon arrival 19____

Immediate cause of death _____

DURATION

Due to _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 7/5/48Where did injury occur? Downsville Md (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public placeManner of injury Drowning Injured at work? Charles Md23. SIGNATURE L. SW Smith actingAddress Washington Md M. D. or other _____Date signed 7/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07635

183

Reg. Dist. No. 304

1. PLACE OF DEATH:

County... WashingtonCity or town... Rural - Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 hoursHospital, institution, or street address where death occurred: —How long in hospital or institution? —

3. (a) FULL NAME

Edward C. McGowan4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Florence B. DockMcGowan 6. (c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) August 11, 18878. AGE: Years 60 Months 10 Days 28 If less than one day — hrs. — min.9. Birthplace Greenport, L.I., New York
(Town, county, and state)10. Usual occupation Painter11. Industry or business —12. Name Hugh M. McGowan13. Birthplace Milford, Mass.14. Maiden name Laura Frances McCarthy15. Birthplace London, England16. Informant Mrs. Mary Jane SpeilmanAddress 140 E. Washington St., Hagerstown, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof July 13, 1948
(month) (day) (year)Cemetery or crematory GreenhillLocation Waynesboro Penna.18. Funeral director Charles R. BastAddress Hancock, Md.19. 7-12-48 Registrar J. H. Keller

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 149 N. Potomac

(If rural, give LOCATION)

2. (a) If veteran, name war World War I

3. (b) Social Security Number

214-09-7335MEDICAL CERTIFICATION About EDT20. DATE OF DEATH July 9 1948, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

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JUL 14 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07636 304
Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Rural - Big Pool
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wash.City or town Rural - Big Pool
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2(a) If veteran, name war _____

3. (a) FULL NAME

Sarah E. Mills

3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Wm McClellan Mills7. Birth date of deceased (mo., day, yr.) Nov. 3, 1869 6. (c) If alive, give age 84 years8. AGE: Years 78 Months 8 Days 6 If less than one day _____ hrs. _____ min.9. Birthplace Washington Co., Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Francois M. McCormick13. Birthplace Washington Co., Md.14. Maiden name Virginia Byroads15. Birthplace Seneca, Md.16. Informant Mrs. Geo. BoswellAddress 3925 22nd St. N.E., Washington, DC17. Burial Date thereof July 12, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Peter's CatholicLocation Hancock, Md.18. Funeral director Charles R. BastAddress Hancock, Md.19. 7-12-48 J. A. Heller
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 9, 1948 at 9:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2, 1948 to July 9, 1948and that I last saw him alive on July 8, 1948Immediate cause of death Chronic Bright's Dis DURATION 2 yrs.Due to Diabetes Insipidus 5 yrs.

Due to _____

Other conditions Arterio Sclerosis 5 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE David R. Brewer M.D. M. D. or otherAddress Clear Spring Md. Date signed July 9, 1948

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JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07637

1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life

Hospital, institution, or street address where death occurred:

630 W. Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 630 W. Washington St
(If rural, give LOCATION)2. (a) If veteran, name war World War 1

3. (a) FULL NAME

Randolph E. Moore

3. (b) Social Security Number

214-09-5710

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Leah H. Moore

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1895

8. AGE:

Years

53

Months

3

Days

26

If less than one day

hrs.

min.

9. Birthplace Washington County, Md.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Hag. Shoe and Legging Co.

FATHER

12. Name Daniel Moore13. Birthplace Washington County, Md.

MOTHER

14. Maiden name Anna Harnish15. Birthplace Washington County, Md.16. Informant Mrs. Leah MooreAddress 630 W. Washington St. Hagerstown, Md.17. Burial Date thereof July 7, 1948
(Burial, cremation, or removal. Which?) (Month) (Day) (Year)Cemetery or crematory River View CemeteryLocation Williamsport, Md.18. Funeral director Fred W. KraissAddress Hagerstown, Md.19. July 6, 1948
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4, 1948 19 48 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-4-48 to 7-4-48 19 48
and that I last saw him in bed 7-4-48 19 48

Immediate cause of death

DURATION

Cerebral Thrombosis2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07638

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown, Maryland
 (if outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Life
 Hospital, institution, or street address where death occurred:
425 West Washington Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (if outside city or town limits, write RURAL and give nearest town)
 Street No. 425 West Washington Street
 (if rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Ruth Naomi Moore

3. (b) Social Security Number

214-09-3804

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Albert L. Moore
 6. (c) If alive, give age 54 years
 7. Birth date of deceased (mo., day, yr.) February 22, 1904
 8. AGE: Years 44 Months 4 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Hagerstown, Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Charles W. Watkins

13. Birthplace Hagerstown, Maryland

14. Maiden name Lydia Ann Koons

15. Birthplace Hagerstown, Maryland

16. Informant Albert L. Moore

Address Hagerstown, Maryland

17. Burial Date thereof 7-10-48
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. July 10, 1948 Registrar Charles W. Watkins

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1948 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1, 1948 to July 5, 1948

and that I last saw him alive on July 5, 1948

Immediate cause of death Sarcoma involving left lung, spine and

Due to 1 year.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William J. ... M. D. or other

Address William J. ... Date signed July 9, 48

RECEIVED

JUL 13 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07639 301

1. PLACE OF DEATH:

County Washington
 City or town Rural Dist.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Charles Mills, Downsville Dist.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State West Virginia County Berkeley Co.
 City or town Shepherdstown, Rt. 2
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

James F. Murphy

3. (b) Social Security Number

214-10-3979

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Glyads Pearrell
 7. Birth date of deceased (mo., day, yr.) (Not Known) 1918
 8. AGE: Years 30 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace West Virginia, Falling Waters
 (Town, county, and state)

10. Usual occupation Operator

11. Industry or business Potomac Edison

12. Name Herbert L. Murphy

13. Birthplace West Virginia

14. Maiden name Bessie K. Wagner

15. Birthplace West Virginia

16. Informant Mrs. James Murphy

Address Martinsburg, W. Va.

17. Burial Date thereof 7-8-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rosedale Cemetery

Location Martinsburg, W. Va.

18. Funeral director Howard K. Brown

Address Martinsburg, W. Va.

19. July 6 48 Mrs. E. Lee McChoy
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 5-48 19 at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5-48 19 July 5-48 19

and that I last saw him at day when died 19 at day when died 19

Immediate cause of death _____

1918

30

1948

RECEIVED

JUL 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 136211

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 DaysHospital, institution, or street address where death occurred:
Washington County HospitalHow long in hospital or institution? 10 Days

3. (a) FULL NAME

Franklin Edward Murray

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Elizabeth R. Murray7. Birth date of deceased (mo., day, yr.) Dec. 10, 1875 6. (c) If alive, give age 71 years

8. AGE: Years 72 Months 6 Days 28 If less than one day
hrs.min.

9. Birthplace Williamsport, Wash., Maryland.
(Town, county, and state)10. Usual occupation Barber11. Industry or business Barbering12. Name John Murray13. Birthplace Williamsport, Md.14. Maiden name Sarah Miller15. Birthplace Williamsport, Md.16. Informant Miss Lulah MurrayAddress 25 W. Potomac St. Williamsport, Md.17. Burial Date thereof July 12, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown, Md.18. Funeral director Edith V. LeafAddress Williamsport, Md.19. July 11, 1948 Registrar
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport
(If outside city or town limits, write RURAL and give nearest town)Street No. 25 West Potomac St.
(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 1948, at 8:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
June 25 1948 to July 8 1948and that I last saw him alive on July 8 1948
Immediate cause of death.....Coronary Occlusion DURATION 1 HourDue to 2Due to Fracture of left shoulder. 10 days

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

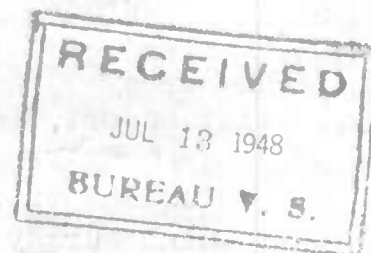
Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE W. B. Bowers M. D.Address Williamsport Md Date signed 7/10/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH:

County... WashingtonCity or town... Roxbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

State Penal Farm

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Roxbury
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John E. Nimmo

3.(b) Social Security Number

NONE

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 19058. AGE: Years Months Days If less than one day
42 11 27 hrs. min.9. Birthplace... Utica, N.Y.
(Town, county, and state)10. Usual occupation... Laborer

11. Industry or business

12. Name... Lindsey Nimmo13. Birthplace... California14. Maiden name... Rose Connolly15. Birthplace... Iowa16. Informant... Charles NimmoAddress... Roselle, N. J.17. Burial Date thereof... 7-14-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Rose Hill CemeteryLocation... Linden, N. J.18. Funeral director... C. M. Suter & SonsAddress... Hagerstown, Maryland19. July 12, 1948 John H. Baer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... July 11 19... 48, at 1⁰⁰ A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 19... 48, to July 11 19... 48and that I last saw him alive on July 10 19... 48Immediate cause of death... Pulm. TuberculosisDURATION
6 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Robert P. Conrad, M.D.Address... Hagerstown, Md. Date signed... 7-12-48

RECEIVED

JUL 16 1948

BUREAU V A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07642 316

1. PLACE OF DEATH:

County WashingtonCity or town Cascade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 8 days

3. (a) FULL NAME

Ada Welty O'Brien

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Thomas O'Brien

7. Birth date of

deceased (mo., day, yr.)

Aug 24 18746. (c) If alive, give age Unknown years

8. AGE:

Years

Months

Days

If less than one day

13115

hrs.

min.

9. Birthplace

Boonsboro, Md.

(Town, county, and state)

10. Usual occupation

Unknown

11. Industry or business

MOTHER FATHER

12. Name

Simon Welty

13. Birthplace

Washington Co.

14. Maiden name

Lucy Fish

15. Birthplace

Washington Co.

16. Informant

Richie Hospital

Address

Cascade Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 31, 1948

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro, Md.

18. Funeral director

Frederick W. K. Ross

Address

Hagerstown, Maryland

19.

(Date rec'd by registrar)

19

48George H. Tassman

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 46 So. Mulberry

(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 19 48 at 8:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21 19 48 to July 29 19 48and that I last saw him/her alive on July 29 19 48

Immediate cause of death

Cerebral arteriosclerosis

DURATION

7

Due to

Due to

Other conditions

Malnutrition
(2) Cardiac decompensation
(Include pregnancy within months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

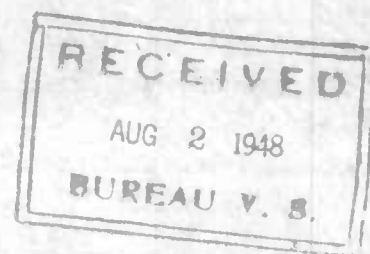
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

T. M. Armstrong, M.D. M. D. or otherAddress Pitchee Hospital Date signed 7/29/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County..... Washington
 City or town..... Cavetown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 years
 Hospital, institution, or street address where death occurred:
Catawaba Road
 How long to hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... Washington
 City or town..... Cavetown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... Catawaba Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

William Anderson Orange

3. (b) Social Security Number

214-09-6501

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Jemima L. Orange
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.)..... Dec. 8, 1886
 8. AGE: Years..... 61 Months..... 7 Days..... 5 If less than one day..... hrs. min.

9. Birthplace..... Amelia Co., Virginia
 (Town, county, and state)
 10. Usual occupation..... Cabinet Maker Cavetown plaining Mills.

11. Industry or business
 12. Name..... William Orange
 13. Birthplace..... Virginia
 14. Maiden name..... George
 15. Birthplace..... Virginia

16. Informant..... Mrs. Jemima L. Orange
 Address..... Cavetown, Maryland
 17. Burial..... Rest Haven Cemetery
 (Burial, cremation, or removal. Which?) Date thereof..... July 14, 1948
 (month) (day) (year)

Cemetery or crematory..... Hagerstown, Maryland
 Location..... Fred W. Kraiss
 18. Funeral director..... Hagerstown, Maryland
 Address.....

19. July 14, 48 20. 48 Geo. W. Ferguson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 12, 1948 at 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
January 7, 1945 to July 12, 1948
 and that I last saw him alive on July 12, 1948

Immediate cause of death..... Coronary thrombosis
 DURATION..... 1 hour

Due to.....
 Due to.....

Other conditions..... Coronary sclerosis
Diabetes mellitus (mild)
 (Include pregnancy within 4 months of death)

Major findings of operations..... None

Date of op.....
 Autopsy results..... No autopsy
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public places (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... La Bue M. D. co-signer
 Address..... Hagerstown Md. Date signed..... 7/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?... Life
 Hospital, institution, or street address where death occurred:
2005 Virginia Avenue
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 48 East Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Elnora Hoover Paulsgrove

3. (b) Social Security Number

217-10-3096

4. Sex... Female 5. Color or race... White 6. (a) Single, married, widowed, or divorced... Widow
 6. (b) Name of husband or wife... Eatl Paulsgrove
 6. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.)... July 10, 1888
 8. AGE: Years... 60 Months... 0 Days... 16 If less than one day... hrs. min.

9. Birthplace... Hagerstown, Wash. Co. Md.
 (Town, county, and state)
 10. Usual occupation... Bookkeeper
 11. Industry or business... Leiter Bros. Store
 12. Name... William Hoover
 13. Birthplace... Hagerstown, Maryland
 14. Maiden name... Agnes Finnigan
 15. Birthplace... Hagerstown, Maryland

16. Informant... William Paulsgrove
 Address... Hagerstown, Maryland
 17. Burial... 7-29-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Rose Hill Cemetery
 Location... Hagerstown, Maryland
 18. Funeral director... C. M. Suter & Sons
 Address... Hagerstown, Maryland

19. July 29, 48
 (Date recd. by registrar) Registrar Black H. Brown

MEDICAL CERTIFICATION

20. DATE OF DEATH... 26 July 19... 48 at... 9:35 P
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
21 July 19... 48 to... 26 July 19... 48
 and that I last saw him alive on... 26 July 19... 48

Immediate cause of death... Carcinoma Stomach
 DURATION... 6-8 mo.

Due to...
 Due to...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations...
 Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE... J. J. Lusby M. D. or other
 Address... 2310 Pittman Date signed... 27 July 48

RECEIVED

JUL 31 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. List correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. 02015

94a

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
304 North Mulberry St.
 How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 304 North Mulberry St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS EDITH PAULINE PRICE

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife George E.

7. Birth date of deceased (mo., day, yr.) June 13, 1895 6.(c) If alive, give age 54 years

8. AGE: Years 53 Months 1 Days 3 If less than one day
 hrs. min.

9. Birthplace Sharpsburg, Washington Co., Md.
(Town, county, and state)10. Usual occupation House Wife11. Industry or business Own Home

FATHER 12. Name William H. Stull
 13. Birthplace Sharpsburg Md.

MOTHER 14. Maiden name Anna K. Kidwell
 15. Birthplace Sheperdstown W. Va.

16. Informant George E. Price
 Address Hagerstown Md.

17. Burial Date thereof 7/18/48
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Mountain View Cemetery
 Location Sharpsburg Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. July 16, 48 Chas H Powers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1948 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1948 to January 16, 1948
 and that I last saw him alive on July 14, 1948
 Immediate cause of death Cerebral thrombosis.

DURATION

2 days

Due to None
 Due to None

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operationAutopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE R. Bee M. D. or otherAddress Hagerstown, Md. Date signed 7/16/48

RECEIVED
JUL 19 1948
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 weeks
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Cool Hollow Road Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hagerstown Md. R. 2.
(If rural, give LOCATION)
2. (a) If veteran, name war no

3. (a) FULL NAME

John Henry Reeder

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Florence South Reeder
7. Birth date of deceased (mo., day, yr.) February - 15 - 1865
6. (c) If alive, give age 83 years
8. AGE: Years 83 Months 4 Days 17 If less than one day hrs. min.

9. Birthplace Robertsville Wash. Co. Md.
(Town, county, and state)
10. Usual occupation Farmer

11. Industry or business

12. Name John Reeder
13. Birthplace Robertsville Wash. Co. Md.
14. Maiden name Malinda Dick
15. Birthplace Robts. Wash. Co. Md.

16. Informant William Reeder
Address Boonsboro Md. R. 2.

17. Burial Burial Date thereof July 4, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Boonsboro Cemetery
Location Boonsboro Md.

18. Funeral director Wm. J. Bost & Sons
Address Boonsboro Md.

19. July 2 19 48 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

E.D.S.T.

20. DATE OF DEATH July 2 19 48 at 4:32 A
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive on 19

Immediate cause of death Generalized vascular arterio
sclerosis
chr myocarditis
Due to Fracture nasal bone
fracture of roof of antrium
Other conditions congestive myocordial heart
failure grade 4
(Include pregnancy within 3 months of death)

Major findings of operations no
Date of op. no
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

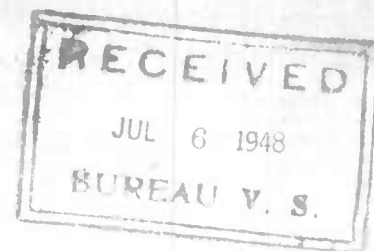
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide homicide Date of 6/10/48
Where did injury occur? Cool Hollow Rd Wash. Md.
(City or town) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury beaten in face Injured at work? no

23. SIGNATURE Dr. Robert Wells WASH. CO., MD.
Address Hagerstown, Md. Date signed 7/2/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



07647

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County Washington
 City or town Rural Sharpsburg MD.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Weeks
 Hospital, institution, or street address where death occurred:
Boonsboro Nurseing Home, Boonsboro Dn.
 How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Sharpsburg Md.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

C. Hicks Remsburg

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife Alice Nicodemus
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 1861 Sept. 30
 8. AGE: Years 86 Months 10 Days 2 If less than one day _____ hrs. _____ min.

9. Birthplace Sharpsburg Md.
 (Town, county, and state)
 10. Usual occupation Farmer
 11. Industry or business Farmer

12. Name William R. Remsburg
 13. Birthplace Sharpsburg Md.
 14. Maiden name Eliza Huffer
 15. Birthplace Sharpsburg Md.

16. Informant Fred Remsburg
 Address Sharpsburg Md.

17. Burial Date thereof July 4 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Mountainview
 Location Sharpsburg Md.

18. Funeral director Edith V Leaf
 Address Williamsport Md.

19. July 3 1948 John H. Past
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1948 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1948 to July 1 1948
 and that I last saw him alive on July 1 1948

Immediate cause of death Angina pectoris - acute DURATION 1 month

Due to Chronic dilatation with retention of urine 1 year

Due to _____

Other conditions Generalized Arterio-sclerosis - Semis 5-year

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Walter A. Shady MD
Sharpsburg, Md M. D. or other _____

Date signed 7/5/48

MARGIN RESERVED FOR BINDING

VS A15 9:45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Robert V. Campbell

Reg. Dist. No. 303

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown R # 5
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 Years
 Hospital, institution, or street address where death occurred:
Security Road
 How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington
 City or town Hagerstown R # 5
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Security Road
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

MRS VIOLA MAY McALLISTER ROHER

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Paul
 7. Birth date of deceased (mo., day, yr.) March 14 1897
 6.(c) If alive, give age 54 years
 8. AGE: Years 51 Months 4 Days 7 hrs. min.

9. Birthplace Clear Springs Wash. Co. Md.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Arch McAllister
 13. Birthplace Indian springs Md
 14. Maiden name Emma Suffacool
 15. Birthplace Clearsprings Md.

16. Informant Paul Roher
 Address Hagerstown Md. R # 5

17. Burial Date thereof 7/24/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rest Haven Cemetery
 Location Hagerstown Md.

18. Funeral director Andrew K. Coffman
 Address Hagerstown Md.

19. July 24 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1948 19 48 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 48 to July 19 48
 and that I last saw him alive on July 10 48
 Immediate cause of death Cerebral thrombosis DURATION

Due to Hypertension, Essential

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Campbell MD M.D. or other

Address Hagerstown Md Date signed 7/23/48

RECEIVED

JUL 27 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07649
380

1. PLACE OF DEATH:

County Washington CountyCity or town Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 78 yrs.Hospital, institution, or street address where death occurred:
Sharpsburg Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Sharpsburg Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. Sharpsburg Md.
(If rural, give LOCATION)

2.(a) If veteran, name War

3.(a) FULL NAME

Viola Benner Schowe

3.(b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Charles Schowe6.(c) If alive, give age 81 years7. Birth date of deceased (mo., day, yr.) Sept 10 18698. AGE: Years 78 Months 9 Days 22 If less than one day
..... hrs. min.9. Birthplace Sharpsburg Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Franklin Benner13. Birthplace Sharpsburg Md.14. Maiden name Amelia Hines15. Birthplace Sharpsburg Md.16. Informant Mr. Charles SchoweAddress Sharpsburg Md.17. Burial Date thereof July 4 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mountain View CemeteryLocation Sharpsburg Md.18. Funeral director Edith V. LeafAddress #7 Church St Williamsport, Md.19. 7/4/48 Earl Boyer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 48 at 1.30 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 19 48 to July 2 19 48and that I last saw him alive on July 2 19 48Immediate cause of death Carcinoma of colon

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Boyer M. D.Address Boonsboro Date signed 7/3/48

RECEIVED

AUG 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07650

83a

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 65 years
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ma. County Wash.
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 56 E. Franklin St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war -

3. (a) FULL NAME

Harry Clinton Schwinger

3. (b) Social Security Number

214-09-8042

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced divorced

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) August 2, 1882 8.(c) If alive, give age 65 years

8. AGE: Years 65 Months 11 Days 12 If less than one day hrs. min.

9. Birthplace Hagerstown, Wash. Co., Md.
 (Town, county, and state)

10. Usual occupation retired

11. Industry or business

12. Name George H. Schwinger
 13. Birthplace Hagerstown, Md.

14. Maiden name Sarah L. Stouffer
 15. Birthplace near Hagerstown, Md.

16. Informant Mrs. Ruth Downey
 Address Downsville, Md.

17. burial Date thereof 7-17-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
Hagerstown, Md.
 Location

19. Funeral director Scott F. Minnich & Son
 Address Hagerstown, Md.

20. July 17, 48 Chas. H. Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 48 at 2:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 19 48 to July 14 19 48
 and that I last saw him alive on July 14 19 48

Immediate cause of death

Cerebral hemorrhage. DURATION 36 hours

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Henderson M. D. or otherAddress Williamstown, Md. Date signed 7/16/48

RECEIVED
JUL 20 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30.5

1. PLACE OF DEATH:

County Washington
 City or town Cappans Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred:
Hagerston Md. R. 3.
 How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Cappans Rural
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Hagerston Md R. 3
 (If rural, give LOCATION)
 2(a) If veteran, name war no

3. (a) FULL NAME

Robert Franklin Shaper

3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

m. w. single

6. (b) Name of husband or wife. 6. (c) If alive, give age years

single7. Birth date of deceased (mo., day, yr.) June - 29 - 1948

8. AGE: Years Months Days If less than one day

— — 5 — hrs. — min.

9. Birthplace Cappans Wash. Co. Md.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name Staley Shaper13. Birthplace Douville Wash. Co. Md.14. Maiden name Florence Zell15. Birthplace Hagerston Wash. Co. Md.16. Informant Staley ShaperAddress Hagerston Md. R. 3.17. Burial Date thereof July 5 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brownlee CemeteryLocation Brownlee Md.18. Funeral director Wm. J. Best & SonAddress Brownlee Md.19. July 5 1948 John H. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 - 1948 at 11:45 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 29 1948 to July 3 1948and that I last saw him alive on July 1 1948Immediate cause of death Asphyxiation

DURATION

Due to Regurgitation and aspiration

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations noneAutopsy results Gastric contents in trachea

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert F. Goodle M. D. or otherAddress 132 W. Wash St Date signed 7-4-48

RECEIVED

JUL 7 1948

BUREAU V. S.

30

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

552

07652

306

Reg. Dist. No.

1. PLACE OF DEATH:

County WashingtonCity or town Parade
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 months 5 days

Hospital, institution, or street address where death occurred:

Bellevue HospitalHow long in hospital or institution? 5 months 5 days

3. (a) FULL NAME

Charles Edward Shuler4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Divorced6. (b) Name of husband or wife Lillian McCord7. Birth date of deceased (mo., day, yr.) Jan 3, 18958. AGE: Years 13 Months 6 Days 24 If less than one day9. Birthplace Westminster, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business Railroad - retired12. Name Josephus Shuler13. Birthplace Lib now14. Maiden name Sarah C. Huff15. Birthplace Union Mills, Md.16. Informant Hospital RecordsAddress Pitche Hospital17. (Burial, cremation, or removal, Which?) Burial Date thereof July 29, 48
(month) (day) (year)Cemetery or crematory St. Johns CemeteryLocation Westminster, Md.18. Funeral director H. Bankard & SonAddress Westminster, Md.19. July 27, 48 19 48 Geo W. Ferguson
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarrollCity or town Westminster
(If outside city or town limits, write RURAL and give nearest town)Street No. 80 Penna. Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 48 at 8:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 19 48 to July 26 19 48and that I last saw him alive on July 25 19 48Immediate cause of death Gastrointestinal hemorrhage DURATION 2 daysDue to Recto-vesico-cutaneous fistula unknown approx 1 yr

Due to

Other conditions Probable carcinomatous, primary site undetermined
(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

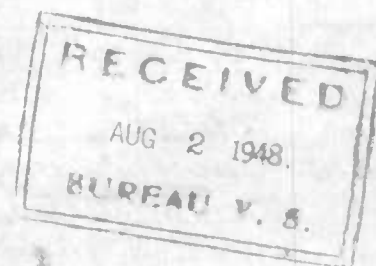
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Arrington, M.D. M. D. or otherAddress Pitche Hospital, Md. Date signed 7/26/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07653 305

1. PLACE OF DEATH:

County WashingtonCity or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yearsHospital, institution, or street address where death occurred:
N. main st.How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)Street No. N. main st.
(If rural, give LOCATION)2. (a) If veteran, name war no.

3. (a) FULL NAME

Violetta Susan Shipley

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Single

6. (c) If alive, give age

years

7. Birth date of

deceased (mo., day, yr.) December - 4 - 1857

8. AGE:

Years

Months

Days

If less than one day

90714

hrs.

min.

9. Birthplace

Locust Grove Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

George Shipley

12. Name

Locust Grove Wash. Co. Md.

13. Birthplace

Elizabeth Huffer

14. Maiden name

Boonsboro Wash. Co. Md.

15. Birthplace

Mrs. Elmer Rohrer

16. Informant

Boonsboro Md.

17. Burial -

(Burial, cremation, or removal. Which?)

Date thereof July 20, 1948

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Wm. J. Bart & Sons

Address

Boonsboro Md.Date July 20, 1948
(Date rec'd by registrar)John H. Bart
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July - 18 - 1948 at 9-A-M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

June - 27 - 1948 to July - 18 - 1948and that I last saw him alive on July 17 - 1948

Immediate cause of death

Fracture of left hip (trauma)
hemorrhage

DURATION

21 days
57

Due to

Dus to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/27/1948

Where did injury occur? (City or town) (County) (State)

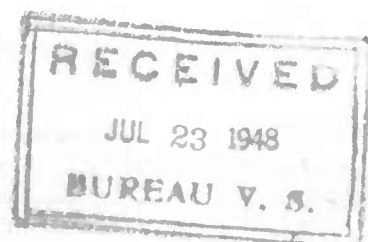
Injured at home, farm, industry, public place (where?) HomeManner of injury slipped on floor injured at work?while working [9/3/48 aka]23. SIGNATURE Robert Wade M.D. M. D. co-signerAddress Boonsboro Md. Date signed 7/19/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 305

07654

462

1. PLACE OF DEATH:

County Washington
City or town Appleton Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
Boonsboro Md. R. 2
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Appleton - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)
2.(a) If veteran, name war no.

3. (a) FULL NAME

Seibert James Shoemaker

3. (b) Social Security Number

217-03-5428

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife Anna Mae Nitz
7. Birth date of deceased (mo., day, yr.) August 28 - 1907
8. AGE: Years 40 Months 11 Days 0 It less than one day hrs. min.
6. (c) If alive, give age years

9. Birthplace New Sharpsburg Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Central Chemical Co.

12. Name George Shoemaker

13. Birthplace Boonsboro Wash. Co. Md.

14. Maiden name Malinda Kline

15. Birthplace Boonsboro Wash. Co. Md.

16. Informant Mrs. Anna Mae Shoemaker

Address Boonsboro Md. R. 2

17. Burial Burial Date thereof July 31 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Cemetery

Location Boonsboro Md.

18. Funeral director Wm. J. Best & Son

Address Boonsboro Md.

19. July 31 1948 John H. Best
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 - 1948 at 7 A - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1948 to July 28 1948

and that I last saw him alive on July 27 1948

Immediate cause of death Carcinoma of Colon

DURATION

7 mos

Due to Carcinoma of Colon

Due to Carcinoma of Colon

Other conditions Carcinoma of Colon

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Colon

Date of op. Carcinoma of Colon

Autopsy results Carcinoma of Colon

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Carcinoma of Colon Date of Carcinoma of Colon

Where did injury occur? Carcinoma of Colon (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Carcinoma of Colon

Means of injury Carcinoma of Colon Injured at work? Carcinoma of Colon

23. SIGNATURE William M. D. M. D. or other

Address Boonsboro Date signed 7/29/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Write correct age especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0765302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mos.
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State W. Va. County MORGAN
 City or town Berkeley Springs
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. none
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

Siler
Mrs. Jessie C. Siler

3. (b) Social Security Number

none

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife J. Hammond Siler
 7. Birth date of deceased (mo., day, yr.) November 16, 1866
 8. AGE: Years 81 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace Berryville, Clarke Co., W. Va.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own home

12. Name William Castleman

13. Birthplace Berryville, W. Va.

14. Maiden name Ann R. Siler

15. Birthplace Berryville, Va.

16. Informant J. Hammond Siler

Address Berkeley Springs, W. Va.

17. Burial Date thereof July 21, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Green Way Cemetery

Location Berkeley Springs, W. Va.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Md.

19. July 19, 48 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 18, 1948 at 1:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-18-48 to 7-18-48 and that I last saw him alive on 7-18-48

Immediate cause of death acute myocardial infarction DURATION 24 hours

Due to juvenile atherosclerosis unknown

Due to hypertension

Other conditions Diabetes mellitus 30 yrs.
Infection & fracture left foot 3 1/2 mo.
 (Include pregnancy within 3 months of death)

Major findings of operations none Date of op. none

Autopsy results none
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of none

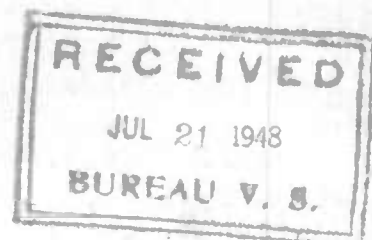
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Stomberg, D. P.

Address 154 W. Washington St. M. D. or other none
Hagerstown, Md. Date signed 7-19-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

119a

07656

Reg. Dist. No. 307

1. PLACE OF DEATH:

County Washington
 City or town Rohersville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington

City or town Rohersville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

Albert Leroy Sines Jr.

3. (b) Social Security Number

no

4. Sex

Male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.)

JUNE 5, 1948

6. (c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

0116

hrs.

min.

9. Birthplace

Rohersville Washington Co. Md.
(Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER

12. Name

Albert L. Sines

13. Birthplace

Middletown Md.

MOTHER

14. Maiden name

Mary Jane Oneal

15. Birthplace

Boonsboro, Md.

16. Informant

Albert L. Sines

Address

Rohersville, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

7-23-48
(month) (day) (year)

Cemetery or crematory

Lutheran Cemetery

Location

Middletown, Md.

18. Funeral director

Address

Bladhill Co. Middletown Md.19. July 22, 1948

(Date rec'd by registrar)

Fun. Katherine Wagner
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

July 2119 48at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 20, 1948 to July 21, 1948and that I last saw him alive on July 20, 1948

Immediate cause of death

Ac. Colitis

DURATION

7 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____

Date of _____

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

J. E. HarpMD

M. D. or other

Address

Middletown

Date signed

7-22-48

RECEIVED

JUL 26 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 17657

1. PLACE OF DEATH:

County Washington
City or town Bonshoro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
S. Main St.
How long in hospital or institution? at home

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Bonshoro
(If outside city or town limits, write RURAL and give nearest town)
Street No. S. Main St.
(If rural, give LOCATION)
2. (a) If veteran, name war no.

3. (a) FULL NAME

Sadie Florence Sinnisen

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced married
6. (b) Name of husband or wife G. S. Sinnisen
7. Birth date of deceased (mo., day, yr.) November - 29 - 1875
6. (c) If alive, give age 72 years
8. AGE: Years 72 Months 7 Days 6 If less than one day hrs. min.

9. Birthplace Myersville, Fred. Co. Md.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own Home

12. Name John F. Poffenberger

13. Birthplace Myersville, Fred. Co. Md.

14. Maiden name Elizabeth Harp

15. Birthplace Myersville, Fred. Co. Md.

16. Informant Miss Florence Sinnisen

Address Bonshoro Md.

17. Burial Date thereof July 8, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bonshoro Cemetery

Location Bonshoro Md.

18. Funeral director Wm. J. Bast & Son

Address Bonshoro Md.

19. July 7 - 1948 John H. Bast
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 5 - 1948 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 4 - 1938 to July 5 - 1948

and that I last saw him live on July 5 - 1948

Immediate cause of death Uremia

Chronic pyelonephritis

Due to Chronic nephritis

Due to Chronic nephritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert Baker M.D.

Address Bonshoro Md. Date signed 7/7/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 9 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93207658

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 years
 Hospital, institution, or street address where death occurred:
431 Carrollton Ave.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland. County Washington
 City or town Hagerstown.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 431 Carrollton Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

George H. Smith

3. (b) Social Security Number

214-09-2286

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Carrie M. Smith
 7. Birth date of deceased (mo., day, yr.) July 7, 1880
 8. AGE: Years 68 Months 0 Days 5 If less than one day _____ hr. _____ min.
 9. Birthplace Mercersburg, Penna.
 (Town, county, and state)
 10. Usual occupation Retired laborer
 11. Industry or business
 12. Name John Smith
 13. Birthplace Penna.
 14. Maiden name Bell Hose
 15. Birthplace Penna.

16. Informant Paul J. Smith
 Address Security, Maryland.
 17. Burial Date thereof July 14, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cemetery
 Location Hagerstown, Maryland.
 18. Funeral director Fred W. Kraiss
 Address Hagerstown, Maryland.
 19. July 14, 1948 Chas H Bowers
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 12 1948 at _____ M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1-48 to 7/12/48
 and that I last saw him alive on 7/12/48
 Immediate cause of death Cerebral Hemorrhage DURATION 1 day
 Due to _____
 Due to _____
 Other conditions Hypertensive Heart Disease 1 yr
 (Include pregnancy within 3 months of death)
 Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 injured at home, farm, industry, public place (where?) _____
 Means of injury _____ injured at work? _____
 23. SIGNATURE Chas H Bowers M. D. or other _____
 Address Hagerstown, Md Date signed 7/14/48

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Washington
 City or town Haystack
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 days
 Hospital, institution, or street address where death occurred:
Washington Co. Hospital
 How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Penn County Fulton
 City or town Big Cove Lannery
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Olive B Snyder

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W
 6. (b) Name of husband or wife Carder Snyder
 7. Birth date of deceased (mo., day, yr.) Nov 22 1887 8. (c) If alive, give age _____ years

8. AGE: Years 60 Months 8 Days 9 If less than one day _____ hrs. _____ min.

9. Birthplace Big Cove Lannery Pa
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business _____

12. Name William M. Eldonney

13. Birthplace Penn

14. Maiden name Elizabeth A Matter

15. Birthplace Fulton Co Pa

16. Informant Carl Matter

Address M. Connellsburg

17. Burial Burial Date thereof Aug 3 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematorium Longway Cem

Location Fulton Co Pa

19. Funeral director J. W. Sipes

Address Hammonville Pa

19. July 31 1948 Registrar Shoast Brown

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31 1948 at 8:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23 1948 to July 31 1948 and that I last saw him alive on July 31 1948

Immediate cause of death _____

Due to _____

Due to _____

Other conditions Intestinal obstruction 7 days

(Include pregnancy within 3 months of death)

Major findings of operations Int

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE RB Youment MD

Address Shoastown Md M. D. or other _____

Date signed 7/31/48

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT

RECEIVED

AUG 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 307

07660

1. PLACE OF DEATH:

County Washington
 City or town Pleasantville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 7 years
 Hospital, institution, or street address where death occurred:
R.F.D.# 1, Harpers Ferry, West Va.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Pleasantville (Rural)
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D.#1, Harpers Ferry, W. Va.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Alice Julia Speaks

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
 6. (b) Name of husband or wife Unknown
 6. (c) If alive, give age --- years
 7. Birth date of deceased (mo., day, yr.) March 15, 1880
 8. AGE: Years 68 Months 4 Days 14 If less than one day --- hrs. --- min.
 9. Birthplace Loudoun County, Virginia
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business Own Home
 FATHER 12. Name Unknown
 13. Birthplace Virginia
 MOTHER 14. Maiden name Unknown
 15. Birthplace Virginia

16. Informant Mrs. Carl Speaks
 Address R.F.D.#1, Harpers Ferry, West Va.
 17. Burial Burial Date thereof Aug. 2, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Samples Manor Cemetery
 Location Samples Manor, Maryland
 18. Funeral director Melvin T. Stinner
 Address Charles Town, West Va.
 19. Aug. 2, 1948 Cornelius H. Castle
 (Date rec'd by registrar) (Signature) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29, 19 48 at 7:00 P.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21, 1948 to July 29, 1948
 and that I last saw him alive on July 29, 1948
 Immediate cause of death Cerebral aneurysm DURATION thrice
 Due to ---
 Due to ---
 Other conditions ---
 (Include pregnancy within 3 months of death)

Major findings of operations --- Date of op. ---
 Autopsy results ---
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

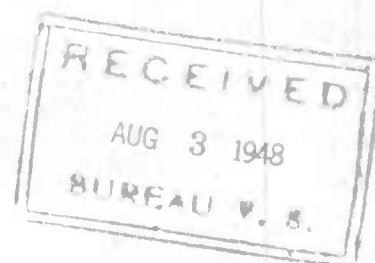
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide --- Date of ---
 Where did injury occur? --- (City or town) --- (County) --- (State)
 Injured at home, farm, industry, public place (where?) ---
 Means of injury --- injured at work? ---
 23. SIGNATURE --- M. D. or other ---
 Address --- Date signed ---

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07661

Reg. Dist. No.

302

1. PLACE OF DEATH:

County... Washington
 City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:
1084 Virginia Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington

City or town... Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1084 Virginia Avenue
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Emma A. Spielman

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Charles E. Spielman

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1870

8. AGE: Year 78 Month 2 Days 2 less than one day
 hrs. min.

9. Birthplace Boonsboro, Wash. Co. Maryland
 (Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

12. Name Andrew Daner

13. Birthplace Washington Co. Md.

14. Maiden name Susan Weist

15. Birthplace Washington Co. Md.

16. Informant Mr. Ezra E. Spielman

Address 1084 Virginia Ave. Hagerstown, Md.

17. Burial Date thereof July 19, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

19. July 19, 48 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 16, 1948 3:00 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4-1-48 to 7-16-48

and that I last saw him alive on 7-16-48

Immediate cause of death

DURATION

Coronary Heart Disease 6 yrs

Due to Chronic Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other

Address [Signature] Date signed 7/16/48

RECEIVED

JUL 21 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Kritzer

07662

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
305 South Potmac St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 305 South Potmac St.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3. (a) FULL NAME

ELIAS EDWARD SPRECHER

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, or divorced Married
8. AGE: Years 77 Months 8 Days 0 (c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) November 9, 1870
10. Usual occupation Gardener
11. Industry or business Retired
12. Name David M. Sprecher
13. Birthplace Hagerstown Md.
14. Maiden name Maria Ringer
15. Birthplace Hagerstown Md.
16. Informant Mrs George Watts
Address Hagerstown Md.
17. Burial Date thereof 7/11/48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rest Haven Cemetery
Location Hagerstown Md.
18. Funeral director Andrew K. Coffman
Address Hagerstown Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH July 9, 1948 at 6:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1948 to July 9, 1948
and that I last saw him alive on July 8, 1948

Immediate cause of death Tuberculosis
DURATION 6 mos.
Due to Strangulation of both feet
Other conditions Debris removed
(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of None
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury None Injured at work?

23. SIGNATURE Harry Kritzer M. D. or other None
Address Hagerstown Md. Date signed 7/9/48

19 July 10, 1948 Registrar Ghost Brown
(Date received by registrar)

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 12 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, institution, or street address where death occurred:
Wash. Co. Hospital
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Benevola - Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Boonsboro md. R. 1
(If rural, give LOCATION)
2. (a) If veteran, name war no

3. (a) FULL NAME

Bessie Magdalene Stine

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Rev. Frank E. Stine
6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) April - 10 - 1878

8. AGE: Years 70 Months 2 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace Eables Mill Wash. Co. md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name John A. Thomas

13. Birthplace Wash. Co. md.

14. Maiden name Hannah Young

15. Birthplace Wash. Co. md.

16. Informant Rev. Frank E. Stine

Address Boonsboro md. R. 1

17. Burial Date thereof July 11, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Boonsboro Mausoleum

Location Boonsboro md.

18. Funeral director Wm. J. Best & Sons

Address Boonsboro md.

19. July 10, 1948 Registrar Robert F. Keadle
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 8, 1948 at 12:15 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 18, 1948 to July 7, 1948 and that I last saw him alive on July 7, 1948

Immediate cause of death Toxemia DURATION

Due to Carcinoma, cervix inoperable 2 yrs.

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert F. Keadle M. D.

Address 132 W. Wash St. Date signed 7-8-48
No. 100 town

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07663

48a

RECEIVED

JUL 13 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07664

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, institution, or street address where death occurred:
333 North Cannon Ave.
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 333 North Cannon Ave.
(If rural, give LOCATION)
2.(a) If veteran, name War None

3. (a) FULL NAME

Daniel Kirk Taylor

3. (b) Social Security Number

None

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Julia Delaney Taylor
7. Birth date of deceased (mo., day, yr.) Jan. 15 - 1883 6.(c) If alive, give age 64 years
8. AGE: Years 65 Months 6 Days 2 If less than one day hrs. min.

9. Birthplace Madison, Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name James R. Taylor
13. Birthplace Elmore Grove
14. Maiden name Mrs. Daniel R. Taylor
15. Birthplace Md.

16. Informant Mrs. Daniel R. Taylor
Address 46 Madison Ave. Shiloh, N.C.

17. Burial Date thereof 7/20/48
(Burial, cremation, or other) (month) (day) (year)
Cemetery or crematory Shiloh
Location Shiloh, N.C.

18. Funeral director Melvin Strider
Address Charlestown West Virginia

19. July 17, 1948
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17, 1948 at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1948 to July 17, 1948
and that I last saw him alive on July 17, 1948

Immediate cause of death Coronary occlusion
Coronary arterio sclerosis
Due to Mrs.

Other conditions Mrs.

(Include pregnancy within 3 months of death)
Major findings of operations Mrs.
Date of op. Mrs.

Autopsy results Mrs.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Mrs. Date of Mrs.
Where did injury occur? Mrs. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Mrs.
Means of injury Mrs. Injured at work?

23. SIGNATURE R. J. ... M. D. or other M.D.
Address Hagerstown, Md. Date signed 7/17/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 20 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

07665

302

186a

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 weeks
Hospital, institution, or street address where death occurred:
Washington County Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Washington
City or town Big Pool
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3.(a) FULL NAME

Louise Catherine Tedrick

3.(b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Daniel H. Tedrick
6.(c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) Dec. 15, 1866
8. AGE: Years 81 Months 6 Days 25 If less than one day _____ hrs. _____ min.

9. Birthplace Washington County, Maryland
(Town, county, and state)
10. Usual occupation Home duties
11. Industry or business _____

12. Name Jacob Shank
13. Birthplace Washington County Maryland
14. Maiden name Eddie
15. Birthplace Washington County Maryland

16. Informant Daniel Roger Tedrick
Address Big Pool, Maryland

17. Burial Date thereof July 13, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Shanktown, Cemetery
Location Near Big Pool, Maryland

18. Funeral director Snyder-Rowland Funeral Home
Address Clearspring, Maryland

19. July 16, 1948 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10, 1948, 5:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1948 to July 10, 1948
and that I last saw him/her alive on July 9, 1948

Immediate cause of death Fractured Hip

Due to Fall in home

Other conditions Cataracts - Both eyes 4 yrs.
Arterio Sclerosis 10 yrs.
(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Acc. Date of 7/9

Where did injury occur? _____
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work? _____

23. SIGNATURE David R. Brewer M.D.
Clear Spring Md. M. D. or other _____
Address _____ Date signed 7/14/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The doctor's age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 19 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 302

07666

170C

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Few Minutes
 Hospital, institution, or street address where death occurred:
Near Hagerstown
 How long to hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Pennsylvania County Franklin Co.
 City or town Mercersburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Park Avenue
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Nathan E. Truax

3. (b) Social Security Number

179-87-3535

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife May Truax
 6. (c) If alive, give age 56 years
 7. Birth date of deceased (mo., day, yr.) August 25, 1884
 8. AGE: Years 63 Months 10 Days 16 It less than one day
 hrs. min.

9. Birthplace Fulton County, Pa.
 (Town, county, and state)
 10. Usual occupation Plumber
 11. Industry or business

FATHER 12. Name Joseph F. Truax
 13. Birthplace Fulton Co. Pa.
 MOTHER 14. Maiden name Mary A. Truax
 15. Birthplace Fulton Co. Pa.

16. Informant Mrs. May Truax
 Address Mercersburg, Pa.

17. Burial 7-15-48 Date thereof (month) (day) (year)
 (Burial, cremation, or removal. Which?)
 Cemetery or crematory Sideling Hill Bapt. Cem.
 Location Fulton Co. Pa.

18. Funeral director W. J. Garrison
 Address Mercersburg Pa.

19. July 12, 48 Date rec'd by registrar
W. J. Garrison Registrar

MEDICAL CERTIFICATION about

July 11 1948 EDT 10:10 PM

20. DATE OF DEATH..... 19..... at.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....

and that I last saw him alive on..... 19.....

Immediate cause of death.....

Fractured skullDue to & shock

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date July 11, 48Where did injury occur? Hagerstown, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) US 40 6mi W. of HagerstownMeans of injury struck by auto Injured at work?

DEPUTY MEDICAL EXAMINER

S. Robert Wells Washington Co., MD.

23. SIGNATURE..... M. D. or.....

Address Hagerstown, Md. Date July 11, 48

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JUL 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr. Richard Campbell
2411 N. Charles St., Baltimore 932 07667
CERTIFICATE OF DEATH Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, institution, or street address where death occurred:
Cavetown Pike
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Pennsylvania County Bucks
City or town New Britain
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2. (a) If veteran, name war None

3. (a) FULL NAME

CHARLES SCRATTON WALLACE

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Bessie
6. (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) March 24, 1873

8. AGE: Years 75 Months 3 Days 27 If less than one day
hrs. min.

9. Birthplace Washington, Warren Co. New Jersey
(Town, county, and state)

10. Usual occupation Contractor

11. Industry or business Carpenter

12. Name Charles Wallace

13. Birthplace Washington New Jersey

14. Maiden name Rebecca Bear

15. Birthplace Broadway New Hersey

16. Informant Mrs Bessie Wallace

Address New Britian Pa.

17. Removal Date thereof 7/24/48
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Beulah Cemetery

Location New Britian, Bucks Co. Penna.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland

19. July 22, 1948 Charles Bowers
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 48 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 21 19 48 to only 19 48

and that I last saw him alive on July 21 19 48

Immediate cause of death

Coronary Disease DURATION ?

Cardio-Vascular Disease

Chronic Vascular 10-12 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mane of injury Injured at work?

23. SIGNATURE Dr. Campbell M. D. or other

Address Hagerstown, Md. Date signed 7/22/48

RECEIVED

JUL 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07668

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: **Washington**
 County **Hagerstown**
 City or town **Fifteen Years**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **24 Hours**
 Hospital, institution, or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? **24 Hours**

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Washington**
 City or town **Hagerstown**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **71 West Side Avenue**
 (If rural, give LOCATION)
 2.(a) If veteran, name war **None Veteran**

3. (a) FULL NAME **George C. Weagley** 3. (b) Social Security Number **705-10-4681**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Married**

6. (b) Name of husband or wife **Emma Mowen**

6. (c) If alive, give age **60** years

7. Birth date of deceased (mo., day, yr.) **January 27, 1886**

8. AGE: Years **62** Months **5** Days **23** (If less than one day) hrs. min.

9. Birthplace **Antrim Township, Frank. Co. Pa.**
 (Town, county, and state)

10. Usual occupation **Blacksmith**

11. Industry or business **Western Maryland Railroad**

12. Name **John Weagley**
 13. Birthplace **Pa.**

14. Maiden name **Unknown**

15. Birthplace **W**

16. Informant **Emma Weagley**

Address **71 West Side Avenue, Hag. Md.**

17. Burial **7-23-48**
 (Burial, cremation, or removal, Which?) Date thereof (month) (day) (year)

Cemetery or crematory **Cedar Hill**

Location **Franklin County, Pa.**

18. Funeral director **W. T. Norment**

Address **Hagerstown, Md.**

19. **July 21, 48** (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **July 20** 19 **48** at **1:14 P.M.**

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from **E.D.T.**

and that I last saw him alive on 19....., 19.....

Immediate cause of death.....

Other conditions.....

Major findings of operation.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **Accidental** Date of **7/8/48**

Where did injury occur? **Hagerstown, Md.**
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **West Side Ave.**

Means **Struck by auto** injured at work? **No**

DEPUTY MEDICAL EXAM. **S. Poles & Wells**

23. SIGNATURE **WASH. CO., MD.**

Address **Hagerstown, Md.** Date signed **7/21/48**

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. This certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 305

1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 Mos 12 Days

Hospital, institution, or street address where death occurred:

Md. State Ref. for MalesHow long in hospital or institution? 11 Mos 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -----City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)Street No. 603 No. Calvert St
(If rural, give LOCATION)2.(a) If veteran, name war None ✓

3. (a) FULL NAME

CALVIN D. WEATHERSPOON

3. (b) Social Security Number

unable to Locate

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleColoredSingle6. (b) Name of husband or wife ---7. Birth date of deceased (mo., day, yr.) December 30 19168. AGE: Years Months Days If less than one day
31 6 13 hrs. min.9. Birthplace Winston-Salem Forsythe Co. No. Car.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business -----12. Name Walter Weatherspoon13. Birthplace Winston-Salem No. Carolina14. Maiden name No. Record15. Birthplace No Record16. Informant Files of Md. State Reformatory for MalesAddress Breathedsville Md.17. Burial Date thereof 7/16/48
(Burial, cremation, or removal) EVERGREEN CEMETERYCemetery or crematory Winston-Salem CemeteryLocation Winston-Salem Forsythe Co. N.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. July 13, 1948 John H. East
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH July 13 1948 19 48 at 2 A. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13 1948
and that I last saw him alive on July 12 1948Immediate cause of death Pulm Tuberculosis DURATION 2 yrsDue to -----Other conditions -----

(Include pregnancy within 3 months of death)

Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Robert P. Conrad, MD M. D. or other -----Address Hagerstown, Md Date signed 7-13-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 16 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:

County Washington
 City or town Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 23 yrs.
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Washington
 City or town Highfield
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Martha Ellen Wolf

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced W
 6.(b) Name of husband or wife Ashby L. Wolf
 7. Birth date of deceased (mo., day, yr.) Feb. 27, 1871
 6.(c) If alive, give age _____ years
 8. AGE: Years 77 Months 5 Days 0 It less than one day _____ hrs. _____ min.
 9. Birthplace Lantz Md.
 (Town, county, and state)
 10. Usual occupation House Duties
 11. Industry or business _____

MOTHER FATHER
 12. Name McAfee
 13. Birthplace Md.
 14. Maiden name Catherine Fisher
 15. Birthplace Md.
 16. Informant Grove A. Wolf
 Address Labillasville, Md.
 17. Burial Date thereof 7/30/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Bethel
 Location _____
 18. Funeral director Walter G. Grove
 Address 271. Church St. Waynesboro Pa
 19. July 29 1948
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1948 at _____ M.
 21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 7-10- 1948 to 7/27/48 and that I last saw him alive on 7/27/48

Immediate cause of death Chronic Myocarditis
 Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE H. C. Bridgers M. D. or other _____
H. C. Bridgers Date signed 7/29/48

RECEIVED

AUG 2 1948

BUREAU V. S.

RECEIVED
AUG 2 1948
BUREAU V. S.